Proposal for a Section 1915(b) Capitated Waiver Program
Waiver Renewal Submittal

September 23, 1999

US DEPARTMENT OF HEALTH AND HUMAN SERVICES
Health Care Financing Administration
Center for Medicaid and State Operations

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PROPOSAL FOR A SECTION 1915(b) CAPITATED WAIVER PROGRAM
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Introduction

The waiver renewal submittal is for a State's use in requesting renewal of an existing Section 1915(b) waiver program involving Managed Care Organizations (MCOs), Health Insuring Organizations (HIOs) or Prepaid Health Plans (PHPs) that provide contracted services to Medicaid enrollees under their care.

The use of this waiver renewal submittal is voluntary. The purpose is to facilitate the waiver renewal process and, thus, minimize unnecessary and cumbersome paperwork requirements. The completion of this request, used in conjunction with State Medicaid Manual instructions at sections 2106-2112, should expedite the State's effort to request the renewal of an existing waiver and HCFA's effort to process the renewal request.

All waiver renewal requests under section 1915(b) of the Social Security Act (the Act) are subject to the requirements that the State document the cost effectiveness of the project, its effect on enrollee access to and quality of services, and its projected impact on the Medicaid program (42 CFR 431.55(b)(2)). This model section 1915(b) waiver renewal submittal will help States provide sufficient documentation in conjunction with a previously completed waiver application submittal for HCFA to be able to determine whether the statutory and regulatory requirements of section 1915(b) of the Act have been satisfied.

Please note the following qualifications: (1) This version of the capitated waiver renewal submittal does not include new requirements proposed for the Medicaid Balanced Budget Act (BBA) regulation for managed care. Once those regulations are promulgated in their final form, waiver renewal requests will need to document compliance with any new requirements the regulations may contain. (2) States must still have MCO contracts and capitation rates prior approved by their HCFA Regional Office.

HCFA staff will be glad to meet with the State, set up a conference call, or assist the State in any way in the completion of the application. States requesting the renewal of a waiver under only Sections 1915(b)(2), 1915(b)(3), or 1915(b)(4), or a combined 1915(b) and 1915(c), waiver should work with their HCFA Regional Office to identify required submission items from this format.

Instructions

This waiver renewal submittal builds upon the new 1999 format for an initial waiver request. It is essentially the same document, with two changes: each section now starts with a request for monitoring results from the previous two-year waiver period, and asks for changes proposed for the next waiver period. In the 1999 initial submittal we asked for a description of the waiver program. In this document we ask not only for the program

description for the next two years, but a description/confirmation of what occurred in the previous two years.

Each section now starts with one or more items under the heading “Previous Waiver Monitoring.” States are asked a couple questions (as appropriate to each Section). First, States are asked to identify any variance between what they said they would do in the last waiver application and what actually happened in the last two years. In a waiver renewal process, HCFA determines whether States adhered to the program descriptions and activities in the previous waiver application. Changes to the waiver program should not be made without obtaining HCFA approval for a modification to the waiver.

In some sections, a second question in “Previous Waiver Monitoring” asks for the results of monitoring various aspects of the waiver program over the previous 2-year waiver period. Please provide a summary of the State’s monitoring results, including any breakdown available by sub-populations (i.e., if you have different or additional monitoring for foster care or SSI children than TANF, please indicate).

Following “Previous Waiver Monitoring” is the subsection called “Upcoming Two Year Period.” Its purpose is to give the State the opportunity to describe the waiver program for the next two years. Within this section States are asked to identify any items which reflect a future change in program from the previous waiver submittal(s) by placing two asterisks (i.e., "**") the item being changed.

Please fill out this form in its entirety. Since this renewal submittal builds on the new 1999 initial submittal, there is not a one-to-one correspondence between sections in this 1999 and the 1995 format. When filling out the “Previous Waiver Monitoring” part of each section, we have tried to identify corresponding sections of the 1995 format when possible. However, States should provide monitoring results from all relevant sections of their previous waiver.

Waiver Submittal Instructions (See State Medicaid Manual 2106)
Please submit an original and four (4) copies of the waiver request to the appropriate office:

For MCO and PCCM programs:

HCFA, Center for Medicaid and State Operations, FCHPG
Attn: Director, Division of Integrated Health Systems
7500 Security Boulevard
Baltimore, MD 21244
For Prepaid Health Plan programs focusing on Behavioral Health or Elderly and Disabled populations:

HCFA, Center for Medicaid and State Operations, DEHPG
Attn: Director, Division of Integrated Health Systems
7500 Security Boulevard
Baltimore, MD 21244

At the same time, send at least one copy of the waiver request to the appropriate HCFA Regional Office. A waiver request submitted under 1915(b) of the Act must be approved, disapproved, or additional information requested within 90 days of receipt, or else the request is deemed granted. The Secretary approves or denies such requests in writing or informs you in writing with respect to any additional information which is needed in order to make a final determination with respect to the request. When additional information is requested, the waiver request must be approved or disapproved within 90 days of receipt of your complete response to the request for additional information, or the waiver request is granted.

The 90-day time period begins (i.e., day number one) on the day the waiver is received by the addressee (i.e., the Secretary, the HCFA Central Office (CO) or Regional Office (RO) designee) and ends 90 calendar days later by which time HCFA must either approve or disapprove the request.

General instructions
States should check all items which apply, and provide additional information when specified. Leaving an item un-checked signifies it is not in the State's waiver program. Please note the following:

- A number of the items are required by federal statute, regulation, or policy. These required items are identified as such either in the instructions or headings for a section, or on an item by item basis. State must check-off these required items to affirm the State's intent to comply. If a required item is not checked, States should explain why it is not.

- All items are applicable to both MCOs and PHPs unless otherwise noted (i.e. only MCO or PHP is referenced in the item)

- For any of the sections that require explanations, if possible, please insert them into the document itself instead of attaching the explanation as an appendix.

- Because this is for a renewal of an existing waiver, HCFA is requesting data or summary results from efforts the State has made during the previous waiver period to ensure compliance, quality of services, enrollee protections, etc. In an effort to ensure a complete submission package and to minimize the amount of additional information requested by HCFA, please be sure to respond to these items as fully as possible so that additional information requests are not necessary.

- If a State modifies the wording of the waiver renewal submittal, please italicize and/or strikeout the modification. States may use italics, underlines, and strikeouts for any State-added information or modification to the standard waiver renewal submittal.

- Please update the table of contents prior to submitting the waiver to HCFA to reflect the current page numbers and appendices.

- Please enclose any attachment directly following the section referenced and number the attachments with the section and question number, (e.g., Attachment C.I.a is the attachment for question a. under point I. Elements of State Quality Strategies in Section C.)

Amendments or modifications during the renewal period

During the renewal period, a State may wish to modify their Section 1915(b) waiver program if an aspect of the program changes. Four (4) copies of the modification request must be submitted to the appropriate CO address listed above. A copy should also be sent to the RO at the same time.

HCFA considers only waiver requests submitted by or through the Governor, State cabinet members responsible for State Medicaid Agency activities, the Director of the State Medicaid Agency, or someone with the authority to submit waiver requests on behalf of the Director.

HCFA reviews the request and makes its recommendation to approve or disapprove the request based on the validity of the request and the documentation that is submitted to support the modification. Approval of modification requests are effective from the date of approval through the end of the renewal period.

HCFA receives a variety of waiver modification requests, which range from being minor in nature to extensive. Regardless of the extent of the needed modification, a State must submit an official request for modification to HCFA as soon as it is aware of the need for a change in its program. The request must be submitted and approved prior to implementation of a change in the waiver program.

Section A. General Impact

I. Background

[Required] Please provide a brief executive summary of the State's 1915(b) waiver program's activities since implementation, including experiences during the previous waiver period(s) and a summary of any program changes either planned or anticipated during the requested renewal period. Please specify the types of stakeholders or other advisory committee meetings that have occurred in the previous waiver period or are expected to occur under the future waiver period. Please include descriptions of any advisory boards that have consumer representation. In addition, please describe any program changes and/or improvements that have occurred as a result of stakeholder involvement during the previous waiver period(s). Please describe any stakeholder involvement in monitoring of the previous waiver period. Finally, to the extent the State enrolls persons with special health care needs, please describe how the various stakeholders have been involved in the development, implementation, and ongoing operation of the program.

II. General Description of the Waiver Program

Previous Waiver Period

a.___ During the last waiver period, the program operated differently than described in the waiver governing that period. The differences were:

Upcoming Waiver Period -- For items a. through m. of this section, please identify any responses that reflect a change in program from the previous waiver submittal(s) by placing two asterisks (i.e., "**") after your response.

a. **The State of** _____requests a waiver under the authority of section 1915(b)(1) of the Act. The waiver program will be operated directly by the Medicaid agency.

b. **Effective Dates:** This waiver renewal is requested for a period of 2 years; effective _____and ending_____.

c. **The waiver program is called**_____.

d. **State Contact:** The State contact person for this waiver is_____and can be reached by telephone at _(___)_____, or fax at _(___)_____, or e-mail at _____.

e. **Type of Delivery Systems:** The State will be entering into the following

types of contracts with the MCO or PHP. The definitions below are taken from federal statute. However, many "other risk" or "non-risk" programs will not fit neatly into these categories (e.g. a PHP program for mental health carve out is "other risk," but just checking the relevant items under "2" will not convey that information fully). Please note this answer should be consistent with your response in Section A.II.d.1 and Section D.I.

1.___ **Risk-Comprehensive (fully-capitated--MCOs, HIOs, or certain PHPs):** Risk-comprehensive contracts are generally referred to as fully-capitated and require that the contractor be an MCO or HIO. Comprehensive means that the contractor is at risk for inpatient hospital services and any other mandatory State plan service in section 1905(a), or any three or more mandatory services in that section. References in this preprint to MCOs generally apply to these risk-comprehensive entities. Check either (a) or (b), and within each the items that apply:

(a)__ The contractor is at-risk for inpatient hospital services and any one of the following services:

i.___ Outpatient hospital services,
ii.___ Rural health clinic (RHC) services,
iii.___ Federally qualified health clinic (FQHC) services,
iv.___ Other laboratory and X-ray services,
v.___ Skilled nursing facility (NF) services,
vi.___ Early periodic screening, diagnosis and treatment (EPSDT) services,
vii.__ Family planning services,
viii.__ Physician services, and
ix.___ Home Health services.

(b)__ The contractor is at-risk for three or more of the above services ((i) through (ix)). Please mark the services in (a) and list the services in Section A.II.d.1.

2.___ **Other Risk (partially-capitated or PHP):** Other risk contracts having a scope of risk that is less than comprehensive are referred to as partially-capitated. PHPs are the contractors in these programs (e.g., a PHP for mental health/substance abuse). References in this preprint to PHPs generally apply to these other risk entities. Please check either (a) or (b); if (b) is chosen, please check the services which apply. In addition to checking the appropriate item, please provide a brief narrative of the other risk (PHP) model, which will be

implemented by the State:

(a)__ The contractor is at-risk for inpatient hospital services,
OR

(b)__ The contractor is at-risk for two or fewer of the below services ((i) through (ix)).

i.___ Outpatient hospital services,
ii.___ Rural health clinic (RHC) services,
iii.___ Federally qualified health clinic (FQHC) services,
iv.___ Other laboratory and X-ray services,
v.___ Skilled nursing facility (NF) services,
vi.___ Early periodic screening, diagnosis and treatment (EPSDT) services,
vii.__ Family planning services,
viii.__ Physician services, and
ix.___ Home Health services.

3.___ **Non-risk:** Non-risk contracts involve settlements based on fee-for-service (FFS) costs (e.g., an MCO contract where the State performs a cost-settlement process at the end of the year). If this block is checked, replace Section D (Cost Effectiveness) of this waiver preprint with the cost-effectiveness section of the waiver preprint application for a FFS primary care case management (PCCM) program. In addition to checking the appropriate items, please provide a brief narrative description of non-risk model, which will be implemented by the State.

4.___ Other (Please provide a brief narrative description of the model. If the model is an HIO, please modify the entire preprint accordingly):

f. **Statutory Authority:** The State's waiver program is authorized under **Section 1915(b)(1) of the Act**, which provides for a capitated managed care program under which the State restricts the entity from or through which a enrollee can obtain medical care.

g. **Other Statutory Authority.** The State is also relying upon authority provided in the following section(s) of the Act:

1.___ **1915(b)(2)** - A locality will act as a central broker (agent, facilitator, negotiator) in assisting eligible individuals in choosing among competing health plans in order to provide enrollees with more information about the range of health care options open to them. See Waiver Preprint Section A.III.B Enrollment/Disenrollment and Section

2105 of the State Medicaid Manual. This section must be checked if the State has an independent enrollment broker.

2.___ **1915(b)(3)** - The State will share cost savings resulting from the use of more cost effective medical care with enrollees by providing them with additional services. Please refer to Section 2105 of the State Medicaid Manual. The savings must be expended for the benefit of the enrolled Medicaid beneficiary.

Please list additional services to be provided under the waiver which are not covered under the State plan in Section A.III.d.1 and Appendix D.III. The services must be for medical or health-related care, or other services as described in 42 CFR Part 440, and are subject to HCFA approval.

3.___ **1915(b)(4)** - The State requires enrollees to obtain services only from specified providers who undertake to provide such services and meet reimbursement, quality, and utilization standards which are consistent with access, quality, and efficient and economic provision of covered care and services. Please refer to Section 2105 of the State Medicaid Manual.

h. Sections Waived. Relying upon the authority of the above Section(s), the State requests a waiver of the following Sections of 1902 of the Act:

1.___ **Section 1902(a)(1)** - Statewideness--This Section of the Act requires a Medicaid State plan to be in effect in all political subdivisions of the State. This waiver program is not available throughout the State.

2.___ **Section 1902(a)(10)(B)** - Comparability of Services--This Section of the Act requires all services for categorically needy individuals to be equal in amount, duration, and scope. This waiver program includes additional benefits such as case management and health education that will not be available to other Medicaid enrollees not enrolled in the waiver program.

3.___ **Section 1902(a)(23)** - Freedom of Choice--This Section of the Act requires Medicaid State plans to permit all individuals eligible for Medicaid to obtain medical assistance from any qualified provider in the State. Under this program, free choice of providers is restricted. That is, individuals enrolled in this program receive certain services through an MCO or PHP.

4.___ **Section 1902(a)(30)** - Upper Payment Limits--This Section of the

Act require that payments to a contractor may not exceed the cost to the agency of providing those same services on a FFS basis to an actuarially equivalent nonenrolled population. Under this waiver, a contractor may receive a capitation rate and any other applicable payment which may cause total payments to the contractor to exceed the upper payment limits for the capitated services in a given waiver year. The waiver must still be cost-effective for the two-year period. An example of a program with this waiver is a partial capitation program, where the State gives the capitated entity (or entities) a bonus (which in conjunction with the capitation payment exceeds the UPL) for reductions in Medicaid expenditures for high cost areas, but the State demonstrates cost-effectiveness on the basis that total waiver program expenditures are less than total without waiver program expenditures.

5.___ **Other Statutes Waived** - Please list any additional section(s) of the Act the State requests to waive, including an explanation of the request. As noted above, States requesting a combined 1915(b) and 1915(c) waiver should work with their HCFA Regional Office to identify required submission items from this format.

i. Geographical Areas of the Waiver Program: Please indicate the area of the State where the waiver program will be implemented. (Note: If the State wishes to alter the waiver area at any time during the waiver period, an official waiver modification request must be submitted to HCFA):

1.____ Statewide -- all counties, zip codes, or regions of the State have managed care (Please list in the table below) or

2.____ Other (please list in the table below):

Regardless of whether item 1 or 2 is checked above, please list in the chart below the areas (i.e., cities, counties, and/or regions) and the name and type of entity (MCO, PHP, HIO, or other entity) with which the State will contract:

City/County/Region	Name of Entity*	Type of Entity (e.g., PHP, Staff model HMO)

*The State should list the actual names of the contracting entities. Cost-

effectiveness data should be submitted for every city/county/region listed here as described in Section D.

j. MCO Requirement for Choice: Section 1932(a)(3) of the Act requires States to permit individuals to choose from not less than two managed care entities.

1.___ This model has a choice of managed care entities.
- (a)__ At least one MCO and PCCM
- (b)__ One PCCM system with a choice of two or more Primary Care Case Managers (please use the PCCM preprint instead of this capitated preprint)
- (c)__ Two or more MCOs
- (d)__ At least one PHP and a combination of the above entities

2.___ This model is an HIO.

3.___ Other: the State requests a waiver of 1932(a)(3). Please list the reasons for the request (Please note: The exception to choice in rural areas, under Section 1932(a)(3) will not apply until final promulgation of the Balanced Budget Act Medicaid Managed Care regulations):

k. Waiver Population Included: The waiver program includes the following targeted groups of beneficiaries. Check all items that apply:

1.___ Section 1931 Children and Related Poverty Level Populations (TANF/AFDC)

2.___ Section 1931 Adults and Related Poverty Level Populations, including pregnant women (TANF/AFDC)

3.___ Blind/Disabled Children and Related Populations (SSI)

4.___ Blind/Disabled Adults and Related Populations (SSI)

5.___ Aged and Related Populations (Please specify: SSI, QMB, Medicare, etc.)

6.___ Foster Care Children

7.___ Title XXI CHIP - includes an optional group of targeted low income children who are eligible to participate in Medicaid if the State has elected the State Children's Health Insurance Program through Medicaid

8.___ Other Eligibility Category(ies)/Population(s) Included - If checked, please describe these populations below.

9.___ Other Special Needs Populations. Please ensure that any special populations in the waiver outside of the eligibility categories above are listed here (Please explain further in Section F. Special Populations)

i.___ Children with special needs due to physical and/ or mental illnesses,
ii.___ Older adults,
iii.___ Foster care children,
iv.___ Homeless individuals,
v.___ Individuals with serious and persistent mental illness and/or substance abuse,
vi.___ Non-elderly adults who are disabled or chronically ill with developmental or physical disability, or
vii.__ Other (please list):

I. Excluded Populations: The following enrollees will be excluded from participation in the waiver:

1.___ have Medicare coverage, except for purposes of Medicaid-only services;

2.___ have medical insurance other than Medicaid;

3.___ are residing in a nursing facility;

4.___ are residing in an Intermediate Care Facility for the Mentally Retarded (ICF/MR);

5.___ are enrolled in another Medicaid managed care program;

6.___ have an eligibility period that is less than 3 months;

7.___ are in a poverty level eligibility category for pregnant women;

8.___ are American Indian or Alaskan Native;

9.___ participate in a home and community-based waiver;

10.__ receive services through the State's Title XXI CHIP program;

11.__ have an eligibility period that is only retroactive;

12.__ are included under the State's definition of Special Needs Populations. Please ensure that any special populations excluded from the waiver in the eligibility categories in l. above are listed here (Please explain further in Section F. Special Populations if necessary);

i.___ Children with special needs due to physical and/ or mental illnesses,
ii.___ Older adults,
iii.___ Foster care children,
iv.___ Homeless individuals,
v.___ Individuals with serious and persistent mental illness and/or substance abuse,
vi.___ Non-elderly adults who are disabled or chronically ill with developmental or physical disability, or
vii.__ Other (please list):

13.__ have other qualifications which the State may exclude enrollees from participating under the waiver program. Please explain those reasons below:

m. Automated Data Processing: Federal approval of this waiver request does not obviate the need for the State to comply with the Federal automated data processing systems approval requirements described in 42 CFR Part 433, Subpart C, 45 CFR Part 95, Subpart F, and Part 11 of the State Medicaid Manual.

n. Independent Assessment: The State will arrange for an Independent Assessment of the cost-effectiveness of the waiver and its impact on enrollee access to care of adequate quality. The Independent Assessment is required for at least the first two waiver periods. **This assessment is to be submitted to HCFA at least 3 months prior to the end of the waiver period**. [Please refer to SMM 2111 and HCFA's "Independent Assessment: Guidance to States" for more information]. Please check one of the following:

1.__ This is the first or second renewal of the waiver. An Independent Assessment has been completed and submitted to HCFA as required.

2.__ Independent Assessments have been completed and submitted for the first two waiver periods. The State is requesting that it not be required to arrange for additional Independent Assessments unless HCFA finds reasons to request additional evaluations as a result of this renewal request. In these instances, HCFA will notify the State

that an Independent Assessment is needed in the waiver approval letter.

III. PROGRAM IMPACT:

In the following informational sections, please complete the required information to describe your program. The questions should be answered for MCOs and, if applicable, for PHPs.

a. **Marketing** including indirect MCO/PHP marketing (e.g., radio and TV advertising for the MCO/PHP in general) and direct MCO/PHP marketing (e.g., direct mail to Medicaid beneficiaries). For information to enrollees (i.e., member handbooks), see Section H.

Previous Waiver Period

1.___ During the last waiver period, the program marketing policies operated differently than described in the waiver governing that period. The differences were:

2.___ [Required for all elements checked in the previous waiver submittal] Please describe how often and through what means the State monitored compliance with its marketing requirements [items A.III.a.1-7 of 1999 initial preprint; as applicable in 1995 preprint], as well as results of the monitoring.

Upcoming Waiver Period Please describe the waiver program for the upcoming two-year period. For items 1. through 7. of this section, please identify any responses that reflect a change in program from the previous waiver submittal(s) by placing two asterisks (i.e., "**") after your response.

1.___ The State does not permit direct or indirect MCO/PHP marketing (go to item “b. Enrollment/Disenrollment”)

2.___ The State permits indirect MCO/PHP marketing (e.g., radio and TV advertising for the MCO/PHP in general). Please list types of indirect marketing permitted.

3.___ The State permits direct MCO/PHP marketing (e.g., direct mail to Medicaid beneficiaries). Please list types of direct marketing permitted.

Please describe the State’s procedures regarding direct and indirect marketing by answering the following questions and/or referencing contract provisions or Requests for Proposals, if applicable.

4.___ The State prohibits or limits MCOs/PHPs from offering gifts or other incentives to potential enrollees. Please explain any limitation/prohibition and how the State monitors this:

5.___ The State permits MCO/PHPs to pay their marketing representatives based on the number of new Medicaid enrollees he/she recruited into the plan. Please explain how the State monitors marketing to ensure it is not coercive or fraudulent:

6.___ The State requires MCO/PHP marketing materials to be translated into the languages listed below (If the State does not translate enrollee materials, please explain):

The State has chosen these languages because (check any that apply):

i.__ The languages comprise all prevalent languages in the MCO/PHP service area.

ii.__ The languages comprise all languages in the MCO/PHP service area spoken by approximately ___ percent or more of the population.

iii.__ Other (please explain):

7.___ The State requires MCO/PHP marketing materials to be translated into alternative formats for those with visual impairments.

8. **MCO Required Marketing Elements**: Listed below is a description of requirements which the State must meet under the waiver program (items 1.a through 1.g). These items are optional PHP marketing elements. If an item is not checked, please explain why. The State:

(a)__ Ensures that all marketing materials are prior approved by the State

(b)__ Ensures that MCO marketing materials do not contain false or misleading information

(c)__ Consults with the Medical Care Advisory Committee (or subcommittee) in the review of MCO marketing materials

(d)__ Ensures that the MCO distributes marketing materials to its entire service area

(e)__ Ensures that the MCO does not offer the sale of any other type of insurance product as an enticement to enrollment.

(f)___ Ensures that the MCO does not conduct directly or indirectly,

door-to-door, telephonic, or other forms of “cold-call” marketing.

(g)__ Ensures that MCO does not discriminate against individuals eligible to be covered under the contract on the basis of health status or need of health services.

b. Enrollment/Disenrollment:

Previous Waiver Period

1.___ During the last waiver period, the enrollment and disenrollment operated differently than described in the waiver governing that period. The differences were:

2. [Required for all elements checked in the previous waiver submittal] Please provide a description of how often and through what means the State has monitored compliance with Enrollment/Disenrollment requirements (items A.III.b of the 1999 initial preprint; items A.8, 9, 17(g-j), 20, and 22 of 1995 preprint). Please include the results from those monitoring efforts for the previous waiver period.

Upcoming Waiver Period - Please describe the State’s enrollment process for MCOs/PHPs by checking the applicable items below. For items 1. through 6. of this section, please identify any responses that reflect a change in program from the previous waiver submittal(s) by placing two asterisks (i.e., "**") after your response.

1.___ **Outreach:** The State conducts outreach to inform potential enrollees, providers, and other interested parties of the managed care program (e.g., media campaigns, subcontracting with community-based organizations or out stationed eligibility workers). Please describe the outreach process, and specify any special efforts made to reach and provide information to special populations included in the waiver program:

2.___ **Administration of Enrollment Process**:

(a)__ State staff conduct the enrollment process.

(b)__ The State contracts with an independent contractor(s) (i.e., enrollment broker) to conduct the enrollment process and related activities. The State must request a waiver of 1915(b)(2) in Section A.II.g.1. (Refer to Section 2105 of the State Medicaid Manual)

i. Broker name: _____
ii. Procurement method:
(A). ____Competitive
(B). ____Sole source
iii. Please list the functions that the contractor will perform:

(c)__ State allows MCOs/PHPs to enroll beneficiaries. Please describe the process and the State's monitoring.

3. **Enrollment Requirement:** Enrollment in the program is:

(a)__ Mandatory for populations in Section A.II.l

(b)__ Voluntary -- See Cost-effectiveness Section D introduction for instructions on inclusion of costs and enrollment numbers (please describe populations for whom it will be voluntary):

(c)___ Other (please describe):

4**. Enrollment:**

(a)__ The State will make counseling regarding their MCO/PHP choices prior to the selection of their plan available to potential enrollees. Please describe location and accessibility of sites for face-to-face meetings and availability of telephone access to enrollment selection counseling staff, the counseling process, and information provided to potential enrollees.

(b)__ Enrollment selection counselors will have information and training to assist special populations and persons with special health care needs in selecting appropriate MCO/PHPs and providers based on their medical needs. Please describe.

(c)__ Enrollees will notify the State/enrollment broker of their choice of plan by:
i. ___ mail
ii.___ phone
iii.___ in person at ____
iv.___ other (please describe):

(d)__ [Required for MCOs and PHPs] There will be an open enrollment period during which the plans will accept individuals who are eligible to enroll. Please describe how long the open enrollment period is and how often beneficiaries are offered open enrollment. Please note if the open enrollment period is

continuous (i.e., there is no enrollment lock-in period).

(e)__ Newly eligible beneficiaries will receive initial notification of the requirement to enroll into the program. Please describe the initial notification process.

(f)___ Mass enrollments are expected. Please describe the initial enrollment time frames or phase-in requirements:

(g)__ If an enrollee does not select a plan within the given time frame, the enrollee will be auto-assigned or default assigned to a plan.

i. Potential enrollees will have____days/month(s) to choose a plan.
ii. Please describe the auto-assignment process and/or algorithm. What factors are considered? Does the auto-assignment process assign persons with special health care needs to an MCO/PHP that includes their current provider or to an MCO/PHP that is capable of serving their particular needs?

(h) __ The State provides guaranteed eligibility of ____ months for all managed care enrollees under the State plan. How and at which point(s) in time are potential enrollees notified of this?

(i)__ The State allows otherwise mandated beneficiaries to request exemption from enrollment in an MCO/PHP. Please describe the circumstances under which an enrollee would be eligible for exemption from enrollment. In addition, please describe the exemption process:

5. **Disenrollment:**

(a)__ The State allows enrollees to disenroll/transfer between MCOs/PHPs. Please explain the procedures for disenrollment/transfer:

(b)__ The State does not allow enrollees to disenroll from the PHP.

(c)__ The State monitors and tracks disenrollments and transfers between MCOs/PHPs. Please describe the tracking and analysis:

(d)__ The State has a lock-in period of ____ months (up to 12

months permitted). If so, the following are required:

i.___ MCO enrollees must be permitted to disenroll without cause within the first 90 days of each enrollment period with each MCO.

ii __ PHP enrollees must be permitted to disenroll without cause within the first month of each enrollment period with each PHP

ii.___ MCO enrollees must be notified of their ability to disenroll or change MCOs at the end of their enrollment period at least 60 days before the end of that period.

iii.___ MCO and PHP enrollees have the following good cause reasons for disenrollment are allowed during the lock-in period:

(e)__ The State does not have a lock-in, and enrollees in MCOs/PHPs are allowed to terminate or change their enrollment without cause at any time. Please describe the effective date of an enrollee disenrollment request.

6. **MCO/PHP Disenrollment of Enrollees**: If the State permits MCOs/PHPs to request disenrollment of enrollees, please check items below which apply:

(a)__ The MCO/PHP can request to disenroll or transfer enrollment of an enrollee to another plan. If so, **it is important that reasons for reassignment are not discriminatory in any way -- including adverse change in an enrollee's health status and non-compliant behavior for individuals with mental health and substance abuse diagnoses -- against the enrollee**. Please describe the reasons for which the MCO/PHP can request reassignment of an enrollee:

(b)__ The State reviews and approves all MCO/PHP-initiated requests for enrollee transfers or disenrollments.

(c)__ If the reassignment is approved, the State notifies the enrollee in a direct and timely manner of the desire of the MCO/PHP to remove the enrollee from its membership.

(d)__ The enrollee remains a member of the MCO/PHP until another MCO/PHP is chosen or assigned.

c. Entity Type or Specific Waiver Requirements

Previous Waiver Period

1.___ During the last waiver period, the program operated differently than described in the waiver governing that period. The differences were:

Upcoming Waiver Period -- Please describe the entity type or specific waiver requirements for the upcoming two-year period. For items 1. through 4. of this section, please identify any responses that reflect a change in program from the previous waiver submittal(s) by placing two asterisks (i.e., "**") after your response.

1.___ **Required MCO/PHP Elements:** MCOs/PHPs will be required to comply with all applicable federal statutory and regulatory requirements, including those in Section 1903(m) and 1932 of the Act, and 42 CFR 434 et seq.

2. **Required Elements Relating to Waiver under Section 1915(b)(4):** If the State is requesting a waiver under Section 1915(b)(4) of the Social Security Act, please mark the items that the State is in compliance with:

(a)__ The State believes that the requirements of section 1915(b)(4) of the Act are met for the following reasons:

i.___ Although the organization of the service delivery and payment mechanism for that service are different from the current system, the standards for access and quality of services are the same or more rigorous than those in your State's Medicaid State Plan.

ii.___ MCO/PHP must provide or arrange to provide for the full range of Medicaid services to be provided under the waiver.

iii.___ MCO/PHP must agree to accept as payment the reimbursement rate set by the State as payment in full.

iv.___ Per 42 CFR 431.55(f)(2)(i), enrollees residing at a long term care facility are not subject to a restriction of freedom of choice based on this waiver authority unless the State arranges for reasonable and adequate enrollee transfer.

v.___ There are no restrictions that discriminate among classes of providers on ground unrelated to their

demonstrated effectiveness and efficiency in providing services.

3. The State has/will select the MCOs/PHPs that will operate under the waiver in the following manner:

   (a)__ The State has used/will use a competitive procurement process. Please describe.

   (b)__ The State has used/will use an open cooperative procurement process in which any qualifying MCO/PHP may participate that complies with federal procurement requirements and 45 CFR Section 74.

   (c)__ The State has not used a competitive or open procurement process. Please explain how the State's selection process is consistent with federal procurement regulations, including 45 CFR Section 74.43 which requires States to conduct all procurement transactions in a manner to provide to the maximum extent practical, open and free competition.

4.___ Per Section 1932(d) of the Act, the State has conflict of interest safeguards with respect to its officers and employees who have responsibilities related to MCO contracts and the default enrollment process now established for MCOs.

d. SERVICES

Previous Waiver Period

1.___ During the last waiver period, the program operated differently than described in the waiver governing that period. The differences were:

2.___ [Required for all elements checked in the previous waiver submittal] Please provide a description of how often and through what means the State has monitored compliance with service provision requirements. [items A.III.d.2-6 of the 1999 initial preprint; items A.13, 14, 21 of the 1995 preprint]. Please include the results from those monitoring efforts for the previous waiver period.

Upcoming Waiver Period -- Please describe the service-related requirements for the upcoming two year period. For items 1. through 7. of this section, please identify any responses that reflect a change in program from the previous waiver submittal(s) by placing two asterisks (i.e., "**") after

your response.

1. The Medicaid services MCO/PHPs will be responsible for delivering, prescribing, or referring to are listed in the chart below. The purpose of the chart is to show which of the services in the State's state plan are/are not in the MCO/PHP contract; which non-covered services are impacted by the MCO/PHP (i.e. for calculating cost effectiveness; see Appendix D.III); and which new services are available only through the MCO/PHP under a 1915(b)(3) waiver. When filling out the chart, please do the following:

(Column 1 Explanation) Services: The list of services below is provided as *an example only. States should modify the list to include:*

-- all services available in the State's State Plan, regardless of whether they will be included or excluded under the waiver
-- subset(s) of state plan amendment services which will be carved out, if applicable; for example, list mental health separately if it will be carved out of physician and hospital services
-- services not covered by the state plan (note: only add these to the list if this is a 1915(b)(3) waiver, which uses cost savings to provide additional services)

(Column 2 Explanation) State Plan Approved: Check this column if this is a Medicaid State Plan approved service. This information is needed because only Medicaid State Plan approved services can be included in cost effectiveness. For 1915(b)(3) waivers it will also distinguish existing Medicaid versus new services available under the waiver.

(Column 3 Explanation) 1915(b)(3) waiver services: If a covered service is not a Medicaid State Plan approved service, check this column. Marking this column will distinguish new services available under the waiver versus existing Medicaid service.

(Column 4 Explanation) MCO/PHP Capitated Reimbursement: Check this column if this service will be included in the capitation or other reimbursement to the MCO/PHP. All services checked in this column should be marked in Appendix D.III in the "Capitated Reimbursement" column.

(Column 5 Explanation) Fee-for-Service Reimbursement: Check this column if this service will NOT be the responsibility of the MCO/PHP, i.e. not included in the reimbursement paid to the MCO/PHP. However, do not include services impacted by the MCO/PHP (see column 6).

(Column 6 Explanation) Fee-for-Service Reimbursement impacted by

MCO/PHP: Check this column if the service is not the responsibility of the MCO/PHP, but is impacted by it. For example, if the MCO/PHP is responsible for physician services but the State pays for pharmacy on a FFS basis, the MCO/PHP will impact pharmacy use because access to drugs requires a physician prescription. All services checked in this column should appear in Appendix D.III (in "Fee-For-Service Reimbursement" column). Do not include services NOT impacted by the MCO/PHP (see column 5).

Service (1)	State Plan Approved (2)	1915(b)(3) waiver services (3)	MCO/PHP Capitated Reimburse-ment (4)	Fee-for-Service Reimburse-ment (5)	Fee-for-Service Reimbursement impacted by MCO/PHP (6)
Day Treatment Services					
Dental					
Detoxification					
Developmental Disabilities Services (please explain)					
Durable Medical Equipment					
Education Agency Services					
Emergency Services					
EPSDT					
Family Planning Services					
Federally Qualified Health Center Services					
Home Health					
Hospice					

Service (1)	State Plan Approved (2)	1915(b)(3) waiver services (3)	MCO/PHP Capitated Reimburse-ment (4)	Fee-for-Service Reimburse-ment (5)	Fee-for-Service Reimbursement impacted by MCO/PHP (6)
Inpatient Hospital - Psych					
Inpatient Hospital - Other					
Immunizations					
Lab and x-ray					
Mental Health Services (Please specify)					
Nurse midwife					
Nurse practitioner					
Nursing Facility					
Obstetrical services					
Occupational therapy					
Other fee-for-service services					
Other Outpatient Services -- Please Specify					
Other Psych Practitioner					
Outpatient Hospital - All Other					
Outpatient Hospital - Lab & X-ray					
Partial					

Service (1)	State Plan Approved (2)	1915(b)(3) waiver services (3)	MCO/PHP Capitated Reimburse-ment (4)	Fee-for-Service Reimburse-ment (5)	Fee-for-Service Reimbursement impacted by MCO/PHP (6)
Hospitalization					
Personal Care					
Pharmacy					
Physical Therapy					
Physician					
Private duty nursing					
Prof. & Clinic and other Lab and X-ray					
Psychologist					
Rehabilitation Treatment Services					
Respiratory care					
Rural Health Clinic					
Speech Therapy					
Substance Abuse Treatment Services					
Testing for sexually transmitted diseases (STDs)					
Transportation - Emergency					
Transportation - Non-emergency					
Vision Exams and					

Service (1)	State Plan Approved (2)	1915(b)(3) waiver services (3)	MCO/PHP Capitated Reimburse-ment (4)	Fee-for-Service Reimburse-ment (5)	Fee-for-Service Reimbursement impacted by MCO/PHP (6)
Glasses					
Other -- Please specify					
Other Pharmacy Services -- Please specify (e.g., Health Drugs)					
Other Mental Health Services-Please Specify					
Other Inpatient Services - Please Specify					

2. **Emergency Services (Required)**. The State must ensure enrollees in MCOs/PHPs have access to emergency services without prior authorization even if the emergency provider does not have a contractual relationship with the entity. For PHPs, "emergency services" means covered inpatient and outpatient services that are furnished by a provider that is qualified to furnish such services, and are needed to evaluate or stabilize an emergency medical condition. For MCOs, "emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, (ii) serious impairment to bodily functions, or (iii) serious dysfunction of any bodily organ or part.

   (a)__ The State has a more stringent definition of emergency medical condition for MCOs or PHPs than the definition above. Please describe.

   The State takes the following required steps to ensure access to

emergency services. If an item below is not checked, please explain.

(b)__ The State ensures enrollee access to emergency services by requiring the MCO/PHP to provide adequate information to all enrollees regarding emergency service access (see Section H. Enrollee Information and Rights)

(c)__ The State ensures enrollee access to emergency services by including in the contract requirements for MCOs/PHPs to cover the following. Please note that this requirement for coverage does not stipulate how, or if, payment will be made. States may give MCOs/PHPs the flexibility to develop their own payment mechanisms, e.g. separate fee for screen/evaluation and stabilization, bundled payment for both, etc.

i.___ For the screen/evaluation and all medically necessary emergency services when an enrollee is referred by the PCP or other plan representative to the emergency room, regardless of whether the prudent layperson definition was met,

ii.___ The screen/evaluation, when an absence of clinical emergency is determined, but the enrollee's presenting symptoms met the prudent layperson definition,

iii.___ Both the screening/evaluation and stabilization services when a clinical emergency is determined,

iv.___ Continued emergency services until the enrollee can be safely discharged or transferred,

v.___ Post-stabilization services which are pre-authorized by the MCO/PHP, or were not pre-authorized, but the MCO/PHP failed to respond to request for pre-authorization within one hour, or could not be contacted (Medicare+Choice guideline). Post-stabilization services remain covered until the MCO/PHP contacts the emergency room and takes responsibility for the enrollee.

3. **Family Planning**: In accordance with 42 CFR 431.51(b), preauthorization by the enrollee's PCP (or other MCO/PHP staff), or requiring the use of participating providers for family planning services is prohibited under the waiver program.

(a)__ Enrollees are informed that family planning services will not be

restricted under the waiver.

(b)__ Non-network family planning services are reimbursed in the following manner:

i.___ The MCO/PHP will be required to reimburse non-network family planning services

ii.___ The MCO/PHP will be required to pay for family planning services from network providers, and the State will pay for family planning services from non-network providers

iii.___The State will pay for all family planning services, whether provided by network or non-network providers

iv.___ The State pays for non-network services and capitated rates were set accordingly.

v.___ Other (please explain):

(c) __ Family planning services are not included under the waiver.

4.___ **Other Services to Which Enrollee Can Self-Refer**: In addition to emergency care and family planning, the State requires MCOs/PHPs to allow enrollees to self-refer (i.e. access without prior authorization) to the following services (Please note whether self-referral is allowed only to network providers or to non-network providers):

5.___ **Monitoring Self-Referral Services**. The State places the following requirements on the MCO/PHP to track, coordinate, and monitor services to which an enrollee can self-refer:

6. **Federally Qualified Health Center** (FQHC) Services will be made available to enrollees under the waiver in the following manner (indicate one of the following, and if the State's methodology differs, please explain in detail below):

(a)__ The program is **voluntary**, and the enrollee can disenroll at any time if he or she desires access to FQHC services. No FQHC services will be required to be furnished by the MCO/PHP to the enrollee during the enrollment period.

(b)__ The program is **mandatory** and the enrollee is guaranteed a

choice of at least one MCO/PHP which has at least one FQHC as a participating provider. If the enrollee elects not to select the MCO/PHP that gives him or her access to FQHC services, no FQHC services will be required to be furnished to the enrollee while the enrollee is enrolled with the MCO/PHP he or she selected. In any event, since reasonable access to FQHC services will be available under the waiver program, FQHC services outside the program will not be available._____

Please explain how the State will guarantee all enrollees will have a choice of at least one MCO/PHP with a participating FQHC:

(c)__ The program is **mandatory** and the enrollee has the right to obtain FQHC services **outside** this waiver program through the regular Medicaid Program.

7. **EPSDT Services:** The State has coordinated and monitored EPSDT services under the waiver program as follows:

(a) __ The State requires MCOs/PHPs to report EPSDT screening data, including behavioral health data (e.g., detailed health and development history including physical and mental health assessments). Please describe the type and frequency of data required by the State.

(b)__ EPSDT screens are covered under this waiver. Please list the State's EPSDT annual screening rates, including behavioral components, for previous waiver period. (Please note*: HCFA requested that each State obtain a baseline of EPSDT and immunization data in the initial application. That baseline could have been the data reported in the HCFA 416 report or it may be rates/measures more specific to the Medicaid managed care population. Those rates from the previous submission should be compared to the current rates and the reports listed here.) Please describe whether screening rates increased or decreased in the previous waiver period and which activities the State will undertake to improve the percentage of screens administered for enrollees under the waiver.

(c) __ Immunizations are covered under this waiver. Please list the State's immunization rates for previous waiver period. What activities will the State initiate to improve immunization rates

for enrollees under the waiver?

(d)__ Managed care providers are required to enroll in the Vaccines for Children Program. If not, please explain.

(e)__ Mechanisms are in place to coordinate school services with those provided by the MCO/PHP. Please describe and clarify the aspects of school services that are coordinated including IEPS, IFSPs, special education requirements, and school-based or school-linked health centers (e.g., plan requirements for PCP cooperation or involvement in the development of the IEPs).

(f)__ Mechanisms are in place to coordinate other aspects of EPSDT (e.g., dental, mental, Title V, etc) with those provided by the MCO/PHP. Please describe.

Section B. Access and Capacity

A Section 1915(b) waiver program serves to improve an enrollee's access to quality medical services. A waiver must assure that services provided are of adequate amount, are provided within reasonable time frames, and are furnished within a reasonable distance from the residence of the enrollees in the program. Furthermore, the proposed waiver program must not substantially impair access to services and access to emergency and family planning services must not be restricted.

I. Access Standards

Previous Waiver Period

a.___ During the last waiver period, the access standards of the program were operated differently than described in the waiver governing that period. The differences were:

Upcoming Waiver Period -- For items a. through c. of this section, please identify any responses that reflect a change in program from the previous waiver submittal(s) by placing two asterisks (i.e., "**") after your response. Please describe the State's availability standards for the upcoming waiver period.

a. **Availability Standards**: The State has established maximum distance and/or travel time requirements, given clients normal means of transportation, for MCO/PHP enrollees' access to the following. Check any that apply (1-9). For each item checked, please describe the standard and answer monitoring questions 10, 11 and 12.

1.___ PCPs (please describe your standard):

2.___ Specialists (please describe your standard):

3.___ Ancillary providers (please describe your standard):

4.___ Pharmacies (please describe your standard):

5.___ Hospitals (please describe your standard):

6.___ Mental Health (please describe your standard):

7.___ Substance Abuse Treatment Providers (please describe your standard):

8.___ Dental (please describe your standard):

9.___ Other providers (please describe your standard):

10. Please explain how often and how the State monitors compliance and what incentives/sanctions/enforcement the State makes with each of the standards described above.

11. Please explain how the distance and travel time to obtain services under the waiver will not be further or longer than prior to the waiver.

12. Please explain how the MCOs/PHPs will be required to enable enrollees to access providers.

b. Appointment Scheduling (Appointment scheduling means the time before an enrollee can acquire an appointment with his or her provider for both urgent and routine visits.) The State has established standards for appointment scheduling for MCO/PHP enrollee's access to the following. Check any that apply (1-9). For each item checked, please describe the standard and answer monitoring questions 10 and 11.

1.___ PCPs (please describe your standard):

2.___ Specialists (please describe your standard):

3.___ Ancillary providers (please describe your standard):

4.___ Pharmacies (please describe your standard):

5.___ Hospitals (please describe your standard):

6.___ Mental Health (please describe your standard):

7.___ Substance Abuse Treatment Providers (please describe your standard):

8.___ Dental (please describe your standard):

9.___ Other providers (please describe your standard):

10. Please explain how often and how the State monitors compliance and what incentives/sanctions/enforcement the State makes with each of the appointment scheduling standards checked above.

11. Please explain how often and how the State assures that appointment scheduling time frames are not longer than the non-waiver appointment scheduling.

c. In-Office Waiting Times: The State has established standards for in-office waiting times for MCO/PHP enrollee's access to the following. Check any that apply (1-9). For each item checked, please describe the standard and answer monitoring questions 10 and 11.

1.___ PCPs (please describe your standard):

2.___ Specialists (please describe your standard):

3.___ Ancillary providers (please describe your standard):

4.___ Pharmacies (please describe your standard):

5.___ Hospitals (please describe your standard):

6.___ Mental Health (please describe your standard):

7.___ Substance Abuse Treatment Providers (please describe your standard):

8.___ Dental (please describe your standard):

9.__ Other providers (please describe your standard):

10. Please explain how often and how the State monitors compliance and what incentives/sanctions/enforcement the State makes with each of the in-office waiting time standards checked above.

11. Please explain how the State assures that in-office waiting times are not longer than the non-waiver in-office waiting times.

II. Access and Availability Monitoring: Enrollee access to care will be monitored as part of each MCO/PHP's Internal Quality Assurance Plan (QAP), annual external quality review (EQR), periodic medical audits, or Independent Assessments (IA).

Previous Waiver Period

a.___ During the last waiver period, the access and availability monitoring was operated differently than described in the waiver governing that period. The differences were:

b.___ [Required for all elements checked in the previous waiver submittal] Please include the results from monitoring MCO/PHP access and availability in the previous two year period. [item B.II in the 1999 initial preprint; items B.4, 5, and 6 in the 1995 preprint].

Upcoming Waiver Period -- For items a. through o. of this section, please identify any responses that reflect a change in program from the previous waiver submittal(s) by placing two asterisks (i.e., "**") after your response. Check below any of the following (a-o) that the State will also utilize to monitor access:

a.___ Measurement of access to services during and after a MCO/PHP's regular office hours to assure 24 hour accessibility, 7 days a week (e.g., PCPs' 24-hour accessibility will be monitored through random calls to PCPs during regular and after office hours)

b.___ Determination of enrollee knowledge on the use of managed care programs

c.___ Ensures that services are provided in a culturally competent manner to all enrollees.

d.___ Review of access to emergency or family planning services without prior authorization

e.___ Review of denials of referral requests

f.___ Review of the number and/or frequency of visits to emergency rooms, non-authorized visits to specialists, etc., for medical care.

g.___ Periodic enrollee experience surveys (which includes questions concerning the enrollees' access to all services covered under the waiver) will be mailed to a sample of enrollees. Corrective actions taken on deficiencies found are also planned.

h.___ Measurement of enrollee requests for disenrollment from a MCO/PHP due to access issues

i.___ Tracking of complaints/grievances concerning access issues

j.___ Geographic Mapping detailing the provider network against beneficiary locations will be used to evaluation network adequacy. (Please explain)

k.___ Monitoring access to prescriptions on the State Plan Formulary, Durable Medical Equipment, and therapies.

l. During monitoring, the State will look for the following indications of access problems.

1.__ Long waiting periods to obtain services from a PCP.

2.__ Denial of referral requests when enrollees believe referrals to specialists are medically necessary.
3.__ Confusion about how to obtain services not covered under the waiver.
4.__ Lack of access to services after PCP's regular office hours.
5.___ Inappropriate visits to emergency rooms, non-authorized visits to specialists, etc., for medical care.
6.__ Lack of access to emergency or family planning services.
7.__ Frequent recipient requests to change a specific PCP.
8.__ Other indications (please describe):

m.__ Monitoring the provision and payment for transportation for beneficiaries to get to their outpatient, medically necessary mental health services.

n.___ Monitoring the provider network showing that there will be providers within the distance/travel times standards.

o.___ Other (please explain):

III. Capacity Standards

Previous Waiver Period

a.___ During the last waiver period, the capacity standards were operated differently than described in the waiver governing that period. The differences were:

b.___ [Required] MCO/PHP Capacity Standards. The State ensured that the number of providers under the waiver remained approximately the same or increased compared to the number before the implementation of the waiver. Please describe the results of this monitoring.

c.___ [Required if elements III.a.1 and III.a.2 were marked in the previous waiver submittal] The State has monitored to ensure that enrollment limits and open panels were adequate and that provider capacity remained approximately the same or improved under the waiver. Please describe the results of this monitoring.

Upcoming Waiver Period -- For items a. through c. of this section, please identify any responses that reflect a change in program from the previous waiver submittal(s) by placing two asterisks (i.e., "**") after your response. Please describe the capacity standards for the upcoming two year period.

a. MCO/PHP Capacity Standards

1.___ The State has set enrollment limits for the MCO/PHPs. Please

describe a) the enrollment limits and how each is determined and b) a description of how often and through what means the limits are monitored and changed.

2.___ The State monitors to ensure that there are adequate open panels within the MCO/PHP. Please describe how often and how the monitoring takes place.

3.___ [Required] The State ensures that the number of providers under the waiver is expected to remain approximately the same or increase compared to the number before the implementation of the waiver. Please describe how the State will ensure that provider capacity will remain approximately the same or improve under the waiver.

4. [Required] For all provider types in the program, list in the chart below for each geographic area(s) applicable to your State, the number of providers before the waiver, during the current waiver period and the number projected for the proposed renewal period. **Please provide a definition of your geographic area,** i.e. by county, region or capitated rate area. Please complete only for the providers included in your waiver program.

For risk-comprehensive programs, please modify to reflect your State's program and complete the following chart:

Providers	# Before the Waiver	# In Current Waiver	# Expected in Renewal
FQHCs			
Hospitals			
Pharmacies			
Primary Care Providers (Please specify) - Family Practice - Internal Medicine - OB/GYNs - Pediatricians - Physician Extenders			
Other (please specify)			

*Please note any limitations to the data in the chart above here:
For other risk programs, please modify for your State's program and complete the following chart:

Providers	# Before the Waiver	# In Current Waiver	# Expected in Renewal
Developmental Disabilities Providers (please specify)			
Hospitals			
Mental Health Providers (please specify)			
Pharmacies			
Substance Abuse Treatment & Rehab Providers (please specify)			
Transportation Providers (please specify)			
Vision Providers			
Other (please specify)			

*Please note any limitations to the data in the chart above here:

b. PCP Capacity Standards

1. The State has set capacity standards for PCPs within the MCOs/PHP expressed in the following terms (In the case of a PHP, a PCP may be defined as a case manager or gatekeeper):

   i.___ PCP to enrollee ratio
   ii.___ Maximum PCP capacity
   iii.__ For PCP contracts with multiple plans, please describe any efforts the State is making to monitor unduplicated Medicaid enrollment capacity across plans?

2.___ The State ensures adequate geographic distribution of PCPs within MCO/PHPs. Please explain.

3.___ The State designates the type of providers that can serve as PCPs. Please list these provider types.

c. Specialist Capacity Standards

1.___ The State has set capacity standards for specialty services. Please explain.

2.___ The State monitors access to specialty services. Please explain how often and how monitoring is done.

3.___ The State requires particular specialist types to be included in the MCO/PHP network. Please identify these in the chart below, modifying the chart as necessary to reflect the specialists in your State's waiver. Please describe the standard if applicable, e.g. speciality to enrollee ratio. If specialists types are not involved in the MCO/PHP network, please describe how arrangements are made for enrollees to access these services (for waiver covered services only).

Specialist Provider Type	Adult	Pediatric	Standards
Addictionologist and/or Certified Addiction Counselors			
Allergist/Immunologist			
Cardiologist			
Chiropractors			
Dentist			
Dermatologist			
Emergency Medicine specialist			
Endocrinologist			
Gastroenterologist			
Hematologist			
Infectious/Parasitic Disease Specialist			

Specialist Provider Type	Adult	Pediatric	Standards
Neurologist			
Obstetrician/Gynecologist			
Oncologist			
Ophthalmologist			
Orthopedic Specialist			
Otolaryngologist			
Pediatrician			
Psychiatrist			
Pulmonologist			
Radiologist			
Surgeon (General)			
Surgeon (Specialty)			
Other mental health providers (please specify)			
Other dental providers(please specify)			
Other (please specify)			

IV. Capacity Monitoring

Previous Waiver Period

a.___ During the last waiver period, the capacity monitoring was operated differently than described in the waiver governing that period. The differences were:

b.___ [Required for all elements checked in the previous waiver submittal] Please include the results from monitoring the MCO/PHP capacity in the previous two year period [item B.IV in the 1999 initial preprint; items A.15-16 in the 1995 preprint].

Upcoming Waiver Period -- For items a. through l. of this section, please identify any responses that reflect a change in program from the previous waiver submittal(s) by placing two asterisks (i.e., "**") after your response.

Please indicate which of the following activities the State employs:

a.___ Periodic comparison of the number and types of Medicaid providers before and after the waiver.

b.___ Measurement of referral rates to specialists.

c.___ Provider-to-enrollee ratios

d.___ Periodic MCO/PHP reports on provider network

e.___ Measurement of enrollee requests for disenrollment from a plan due to capacity issues

f.___ Tracking of complaints/grievances concerning capacity issues

g.___ Geographic Mapping (please explain)

i.___ Tracking of termination rates of PCPs

j.___ Review of reasons for PCP termination

k.__ Consumer Experience Survey, including persons with special needs,

l.__ Other (Please explain):

V. Continuity and Coordination of Care Standards

Previous Waiver Period

a.___ During the last waiver period, the continuity and coordination of care standards were operated differently than described in the waiver governing that period. The differences were:

Upcoming Waiver Period -- For items a. through h. of this section, please identify any responses that reflect a change in program from the previous waiver submittal(s) by placing two asterisks (i.e., "**") after your response. Check any of the following that the State requires of the MCO/PHP:

a.___ Each enrollee selects or is assigned to a primary care provider appropriate to the enrollee's needs

b.___ Each enrollee selects or is assigned to a designated health care practitioner who is primarily responsible for coordinating the enrollee's overall health care.

c.___ Health education/promotion. Please explain.

d.___ Each provider maintains, for Medicaid enrollees, health records that meet the requirements established by the MCO/PHP, taking into account professional standards

e.___ There is appropriate and confidential exchange of information among providers.

f.___ Informs enrollees of specific health conditions that require follow-up and, if appropriate, provides training in self-care

g.___ Deals with factors that hinder enrollee compliance with prescribed treatments or regimens.

h.___ Case management (please define your case management programs)

VI. Continuity and Coordination of Care Monitoring

Previous Waiver Period

a.___ During the last waiver period, the continuity and coordination of care monitoring was operated differently than described in the waiver governing that period. The differences were:

b.___ [Required for all elements checked in the previous waiver submittal] Please include the results from monitoring continuity and coordination of care in the previous two year period [item B.VI in the 1999 initial preprint; Section B (as applicable) in 1995 preprint].

c.___ [Required for all elements checked in the previous waiver submittal] Please describe any continuity or coordination of care requirements (i.e., information sharing requirements or any efforts that the State has required to avoid duplication of services) with these entities that the State required during the previous waiver period for the entities marked in B.VI in the previous waiver submission. These requirements do not include monitoring efforts.

d.___ [Required for all elements checked in the previous waiver submittal if this is a PHP mental health, substance abuse, or developmentally disabled population waiver] Please describe the State's efforts during the previous waiver period to ensure that primary care providers in FFS, PCCM or MCO programs and PHP providers are educated about how to detect MH/SA problems for both children and adults and where to refer clients once the problems are identified. Please describe the requirements for coordination

between FFS, PCCM, or MCO providers and PHP providers. Please describe how this issue is being addressed in the PHP program.

e.___ [Required if this is a PHP mental health, substance abuse, or developmentally disabled population waiver] Please describe how pharmacy services prescribed to program enrollees are monitored in this waiver program. In addition, please note if pharmacy services are not covered under this program.

Upcoming Waiver Period -- For items a. through c. of this section, please identify any responses that reflect a change in program from the previous waiver submittal(s) by placing two asterisks (i.e., "**") after your response. Please describe how standards for continuity and coordinations of care will be monitored in the upcoming two year period.

a. How often and through what means does the State monitor the coordination standards checked above?

b. Specify below any providers (which are excluded from the capitated waiver) that the State explicitly requires the MCO/PHP to coordinate health care services excluded from the capitated waiver with:

1.___ Mental Health Providers (please describe how the State ensures coordination exists):

2.___ Substance Abuse Providers (please describe how the State ensures coordination exists):

3.___ Local Health Departments (please describe how the State ensures coordination exists):

4.___ Dental Providers (please describe how the State ensures coordination exists):

5.___ Transportation Providers (please describe how the State ensures coordination exists):

6.___ HCBS (1915c) Service (please describe how the State ensures coordination exists):

7.___ Developmental Disabilities (please describe how the State ensures coordination exists):

8.___ Title V Providers (please describe how the State ensures

coordination exists):

9.___ Women, Infants and Children (WIC) program
10.__ Indian Health Services providers

11.__ FQHCs and RHCs not included in the program's networks

12.__ Other (please describe):

Section C. QUALITY OF CARE AND SERVICES

A Section 1915(b) waiver program may not substantially impair enrollee access to medically necessary services of adequate quality. In addition, 1915(b) waiver programs which utilize MCOs or PHPs must meet certain statutory or regulatory requirements addressing quality of health care. This section of the waiver submittal will document how the State has monitored and plans to meet these requirements.

I. Elements of State Quality Strategies: -- This section provides the State the opportunity to describe the specifications it has implemented to ensure the delivery of quality services. To the extent appropriate, the specifications address quality considerations and activities for special needs populations.

Previous Waiver Period

a.___ During the last waiver period, the Elements of State Quality Strategies were different than described in the waiver governing that period. The differences were:

b.___ [Required] Describe the results of monitoring MCO/PHP adherence to State standards for internal Quality Assurance Programs during the previous two-year period [item C.I.b in 1999 initial preprint; Item B.1 in 1995 preprint].

c.___ [Required for MCOs] Summarize the results of reports from the External Quality Review Organization. Describe any follow-up done/planned to address study findings [item C.I.c in 1999 initial preprint; item B.2 in 1995 preprint].

d.___ [Required for PHPs and MCOs] Describe the results of periodic medical audits, and any follow-up done/planned to address audit findings [item C.I.d in 1999 initial preprint; item B.3 in 1995 preprint].

e.___ [MCOs only] Intermediate sanctions were imposed during the previous waiver period. Please describe.

Upcoming Waiver Period -- Please check any of the items below that the State requires. For items a through i, please identify any responses that reflect a change in program from the previous waiver submittal(s) by placing two asterisks (i.e., "**") after your response. Note: Elements a - g are requirements for States. Elements c, d and e are required for States which contract with MCOs and element d is required for States which contract with PHPs. The State:

a.__ Includes in its contracts with MCOs/PHPs, the State-required internal QAP standards. Please submit a copy of the State's Quality Assurance and Performance Improvement (QAPI) standards and/or guidelines currently

required of MCOs/PHPs in their contracts as an attachment to this section (Attachment C.I.a).

b.__ Monitors, on a continuous basis, MCOs/PHPs adherence to the State standards, through the following mechanisms (check all that apply):

1.__ Review and approve each MCOs/PHPs written QAP. Such review shall take place prior to the State's execution of the contract with the MCO/PHP.

2.__ Review each MCOs/PHPs written QAP on a periodic schedule after the execution of the contract. Please specific frequency:
_____

3.__ On-site (MCO/PHP administrative offices or service delivery sites) monitoring of the implementation of the QAP to assure compliance with the State's Quality standards. Such monitoring will take place (specify frequency) _____ for each MCO/PHP or attach the scope of work from the EQRO contract as an attachment to this section.

4.__ Conducts monitoring activities using (check all that apply):

(a)__ State Medicaid agency personnel

(b)__ Other State government personnel (please specify):

(c)__ A non-State agency contractor (please specify):

5.__ Other (please specify):

c.__ Will arrange for an annual, independent, external review of the quality outcomes and timeliness of, and access to items and services delivered under each MCO contract with the State. Note: Until additional guidance on EQR is released, please refer to existing regulations, State Medicaid Manual guidance, and the Quality Reform Initiative guidance in this area.

1. Please specify the name of the entity:

2. The entity type is:
(a)__ A Peer Review Organization (PRO).
(b)__ A private accreditation organization approved by HCFA.
(c)__ A PRO-like entity approved by HCFA.

3. Please describe the scope of work for the External Quality Review Organization (EQRO):

d.__ Has established a system of periodic medical audits of the quality of, and access to, health care for each MCO/PHP on at least an annual basis. These audits will identify and collect management data (including enrollment and termination of Medicaid enrollees and utilization of services) for use by medical audit personnel. Note: Until additional guidance on EQR is released, please refer to existing regulations, State Medicaid Manual guidance, and the Quality Reform Initiative guidance in this area. States may, at their option, institute EQR reviews for PHPs. These periodic medical audits will be conducted by:

1. The entity type is:
   (a)__ State Medicaid agency personnel
   (b)__ Other State government personnel (please describe):
   (c)__ A non-State agency contractor to the State (please describe):
   (d)__ Other (please describe):

2. Please attach the scope of work for the periodic medical audits.

e.__ Has established intermediate sanctions that it may impose if the State makes a determination that an MCO violates one of the provisions below. (Note: does not apply to PHPs).

f.__ Has an information system that is sufficient to support initial and ongoing operation and review of the State's QAPI.

g.__ Has standards in the State QAPI, at least as stringent as those required in federal regulation, for access to care, structure and operations, quality measurement and improvement and consumer satisfaction.

h.__ Plans to develop and implement the use of QISMC in its quality oversight of MCOs/PHPs? (QISMC is a HCFA initiative to strengthen MCOs/PHPs' efforts to protect and improve the health and satisfaction of Medicare and Medicaid enrollees. The QISMC standards and guidelines are key tools that can be used by HCFA and States in implementing the quality assurance provisions of the Balanced Budget Act (BBA) of 1997. This is strictly a voluntary initiative for States) Please explain which domains will the State be implementing (check all that apply).

1.__ Domain 1 - Quality Assessment and Performance Improvement (QAPI) Program: Date of Implementation _____

2.__ Domain 2 - Enrollee Rights: Date of Implementation _____

3.__ Domain 3 - Health Services Management :
Date of Implementation _____

4.__ Domain 4 - Delegation: Date of Implementation _____

i.__ Other (please describe)**:**

II. Coverage and Authorization of Services

Previous Waiver Period

a.___ During the last waiver period, coverage and authorization of services were different than described in the waiver governing that period. The differences were:

b.___ [Required for all elements checked in the previous waiver submittal] Please provide results from the State's monitoring efforts for compliance in the area of coverage and authorization of services for the previous waiver period, including a summary of any issues/trends identified in the areas of authorization of services and under/over utilization [items C.II.a-e in 1999 initial preprint; relevant sections of the 1995 preprint]. Please include the results from those monitoring efforts for the previous waiver period.

Upcoming Waiver Period -- Please check any of the processes and procedures from the following list that the State requires to ensure that contracting MCOs/PHPs meet coverage and authorization requirements. For items a through e, please identify any responses that reflect a change in program from the previous waiver submittal(s) by placing two asterisks (i.e., "**") after your response. Contracts with MCOs/PHPs:

a.___ Identify, define and specify the amount, duration and scope of each service offered, differentiating those services, which may be only available to special needs populations, as appropriate.

b.___ Specify what constitutes "medically necessary services" consistent with the State's Medicaid State Plan program (i.e., the FFS program). Please list that specification or definition:

c.___ Provide that the MCO/PHP furnishes the services in accordance with the specification or definition of "medically necessary services".

d.___ Ensure implementation of written policies and procedures reflecting current

standards of medical practice and qualifications of reviewers for processing requests for initial authorization of services or requests for continuation of services. Policies include:

1.___ Specific time frames for responding to requests,

2.___ Requirements regarding necessary information for authorization decisions,

3.___ Provisions for consultation with the requesting provider when appropriate,

4.___ Providing for expedited response for urgently needed services

5.___ Clearly documented criteria for decisions on coverage and medical necessity that are based on reasonable medical evidence or a consensus of relevant medical professionals.

6.___ Criteria for decision on coverage and medical necessity are updated regularly.

7.___ Mechanisms to ensure consistent application of review criteria and compatible decisions.

8.___ A process for clinical peer reviews of decisions to deny authorization of services on the grounds of medical appropriateness.

9.___ Processes and procedures that ensure prompt written notification of the enrollee and provider when a decision is made to deny, limit, or discontinue authorization of services. (Note: current regulations require notice for a termination, reduction, or suspension of services which have already been authorized or when a claim for services is not acted upon with reasonable promptness. This check box should be marked when the State also requires notice when an enrollee's request for future services is denied, limited, or discontinued.) Notices include (check all that apply):

(a)__ Criteria used in denying or limiting authorization

(b)__ Information on how to request reconsideration of the decision.

(c)__ Other (please describe):

10.__ Mechanisms that allow providers to advocate on behalf of enrollees within the utilization management process.

11.__ Mechanisms to detect both underutilization and over utilization of services.

12.__ Other (please describe):

e.___ Other (please describe):

III. Selection and Retention of Providers

Previous Waiver Period

a.___ During the last waiver period, the selection and retention of providers were different than described in the waiver governing that period. The differences were:

b.___ [Required for all elements checked in the previous waiver submittal] Please provide a description of how often and through what means the State monitored the process for selection and retention of providers checked in the previous waiver submittal [items C.III.a-h in the 1999 initial preprint; relevant sections of the 1995 preprint]. Also please provide results from the State's monitoring efforts for compliance in the area of selection and retention of providers for the previous waiver period.

Upcoming Waiver Period

Please check any processes or procedures listed below that the State uses to ensure that each MCO/PHP implements a documented selection and retention process for its providers. For items a through h, please identify any responses that reflect a change in program from the previous waiver submittal(s) by placing two asterisks (i.e., "**") after your response. The State requires MCOs/PHPs to (please check all that apply):

a.___ Develop and implement a documented process for selection and retention of providers.

b.___ Have an initial credentialing process for physicians and other licensed health care professionals including members of physician groups that is based on a written application and site visits as appropriate, as well as primary source verification of licensure, disciplinary status, and eligibility for payment under Medicaid.

c.___ Have a recredentialing process for physicians and other licensed health care professionals including members of physician groups that is accomplished within the time frames set by the State, and through a process that updates information obtained through the following (check all that apply):

1.___ Initial credentialing

2.___ Performance indicators, including those obtained through the following (check all that apply):

(a)__ The quality assessment and performance improvement program
(b)__ The utilization management system

(c)__ The grievance system

(d)__ Enrollee satisfaction surveys

(e)__ Other MCO/PHP activities as specified by the State.

d.___ Use formal selection and retention criteria that do not discriminate against particular practitioners, such as those who serve high risk populations, or specialize in conditions that require costly treatment.

e.___ Determine, and redetermine at specified intervals, appropriate licensing/ accreditation for each institutional provider or supplier. Please describe any licensing/accreditation intervals required by the State

_____

f.___ Have an initial and recredentialing process for providers other than individual practitioners (e.g., home health agencies) to ensure that they are and remain in compliance with any Federal or State requirements (e.g., licensure).

g.___ Notify licensing and/or disciplinary bodies or other appropriate authorities when suspensions or terminations of providers take place because of quality deficiencies.

h.___ Other (please describe):

IV. Delegation

Previous Waiver Period

a.___ During the last waiver period, delegation was different than described in the waiver governing that period. The differences were:

b.___ [Required for all elements checked in the previous waiver submittal] Please provide results from the State's monitoring efforts for compliance in the area

of delegation for the previous waiver period [items C.IV.a-i in 1999 initial preprint; relevant sections of the 1995 preprint].

Upcoming Waiver Period

Please check any of the processes and procedures from the following list that the State uses to ensure that contracting MCOs/PHPs oversee and are accountable for any delegated functions in Section C. Quality of Care and Services. For items a through i, please identify any responses that reflect a change in program from the previous waiver submittal(s) by placing two asterisks (i.e., "**") after your response. Where any functions are delegated by MCOs/PHPs, the State Medicaid Agency:

a.___ Reviews and approves (check all that apply):

1.___ All subcontracts with individual providers or groups

2.___ All model subcontracts and addendums

3.___ All subcontracted reimbursement rates

4.___ Other (please describe):

b.___ Requires agreements to be in writing and to specify any delegated responsibilities.

c.___ Requires agreements to specify reporting requirements.

d.___ Requires written agreements to provide for revocation of the delegation or other remedies for inadequate performance.

e.___ Monitors to ensure that MCOs/PHPs have evaluated the entity's ability to perform the delegated activities prior to delegation.

f.___ Ensures that MCOs/PHPs monitor the performance of the entity on an ongoing basis.

g.___ Monitors to ensures that MCOs/PHPs formally review the entity's performance at least annually.

h.___ Ensures that MCOs/PHPs retain the right to approve, suspend or terminate any provider when they delegate selection of providers to another entity.

i.___ Other (please explain):

V. Practice Guidelines

Previous Waiver Period

a.___ During the last waiver period, practice guidelines were different than described in the waiver governing that period. The differences were:

b.___ [Required for all elements checked in the previous waiver submittal] Please provide results from the State's monitoring efforts to determine the level of compliance in the area of practice guidelines for the previous waiver period [items C.V.a-h in 1999 initial preprint; relevant sections of the 1995 preprint].

Upcoming Waiver Period - Please check any of the processes and procedures from the following list that the State requires to ensure that contracting MCOs/PHPs adopt and disseminate practice guidelines (please check all that apply). For items a through h, please identify any responses that reflect a change in program from the previous waiver submittal(s) by placing two asterisks (i.e., "**") after your response. Guidelines:

a.___ Are based on reasonable medical evidence or a consensus of health care professionals in the particular field.

b.___ Consider the needs of the MCOs/PHPs enrollees.

c.___ Are developed in consultation with contracting health professionals.

d.___ Are reviewed and updated periodically.

e.___ Are disseminated to all providers, all enrollees (as appropriate) and individual enrollees upon request.

f.___ Are applied in decisions with respect to utilization management, enrollee education, coverage of services, and other relevant areas.

g.___ Develop and implement policies and procedures for evaluating new medical technologies and new uses of existing technologies.

h.___ Other (please explain):

VI. Health Information Systems

Previous Waiver Period

a.___ During the last waiver period, health information systems of contracting MCOs/PHPs were different than described in the waiver governing that period. The differences were:

b.___ [Required for all elements checked in the previous waiver submittal] Please provide results from the State's monitoring efforts for compliance in the area of health information systems for the previous waiver period [items C.VI.a-i in 1999 initial preprint; relevant sections of the 1995 preprint].

c.___ Please provide a description of the current status of the State's encounter data system, including timeliness of reporting, accuracy, completeness and usability of data provided to the State by MCOs/PHPs.

d.___ The State uses information collected from MCOs/PHPs as a tool to monitor and evaluate MCOs/PHPs (i.e. report cards). Please describe.

e.___ The State uses information collected from MCOs/PHPs as a tool to educate beneficiaries on their options (i.e. comparison charts to be used by beneficiaries in the selection of MCOs/PHPs and/or providers). Please describe.

Upcoming Waiver Period

Please check any of the processes and procedures from the following list that the State requires to ensure that contracting MCOs/PHPs maintain a health information system that collects, analyzes, integrates, and reports data and can achieve the objectives of the Medicaid Program. For items a through i, please identify any responses that reflect a change in program from the previous waiver submittal(s) by placing two asterisks (i.e., "**") after your response. The State requires that MCOs/PHPs systems:

a.___ Provide information on
1.___ Utilization,
2.___ Grievances,
3.___ Disenrollment.

b.___ Collect data on enrollee and provider characteristics as specified by the State.

c.___ Collect data on services furnished to enrollees through an encounter data system or such other methods approved by the State (please describe). The MCO/PHP is capable of (please check all that apply):

1.___ [Required] Recording sufficient patient data to identify the provider who delivered services to Medicaid enrollees

2.___ [Required] Verifying whether services reimbursed by Medicaid were actually furnished to enrollees by providers and subcontractors

3.___ Verifying the accuracy and timeliness of data

4.___ Screening data for completeness, logic and consistency

5.___ Collecting service information in standardized formats to the extent feasible and appropriate

6.___ Other (please describe):

d.___ Provide periodic numeric data and/or narrative reports describing clinical and related information for the Medicaid enrolled population in the following areas (check all that apply):

1.___ Health services (please specify frequency and provide a description of the data and/or content of the reports)

2.___ Outcomes of health care (please specify frequency and provide a description of the data and/or content of the reports)

3.___ Encounter Data (please specify frequency and provide a description of the data and/or content of the reports)

4.___ Other (please describe and please specify frequency and provide a description of the data and/or content of the reports)

e.___ Maintain health information systems sufficient to support initial and ongoing operation, and that collect, integrate, analyze and report data necessary to implement its QAP.

f.___ Ensure that information and data received from providers are accurate, timely and complete.

g.___ Allow the State agency to monitor the performance of MCOs/PHPs using systematic, ongoing collection and analysis of valid and reliable data.

h.___ Ensure that each provider furnishing services to enrollees maintains an enrollee health record in accordance with standards established by the organization that take into account professional standards.

i.___ Other (please describe):

VII. Quality Assessment and Performance Improvement (QAPI)

Previous Waiver Period

a.___ During the last waiver period, the State's Quality Assessment and Performance Improvement (QAPI) program was different than described in the waiver governing that period. The differences were:

b.___ [Required for all elements checked in the previous waiver submittal] Please provide results from the State's monitoring efforts to determine the level of compliance in the area of QAPI for the previous waiver period [items C.VII.a-u in 1999 initial preprint; relevant sections in the 1995 preprint]. Please break down monitoring results by subpopulations if available.

c.___ The State or its MCOs/PHPs conducted performance improvement projects that achieve, through on-going measurement and intervention, demonstrable and sustained improvement in significant aspects of clinical care and non-clinical services that can be expected to have a beneficial effect on health outcomes and enrollee satisfaction. Please list and submit findings from the projects completed in the previous two year period.

Upcoming Waiver Period- Please check any of the processes and procedures from the following list that the State requires to ensure that contracting MCOs/PHPs maintain an adequate QAPI. For items a through u, please identify any responses that reflect a change in program from the previous waiver submittal(s) by placing two asterisks (i.e., "**") after your response. The State requires that MCOs/PHPs (check all that apply and note in narratives if the State intends to break down the results by subpopulation):

a.___ Have an adequate organizational structure which allows for clear and appropriate administration and evaluation of the QAPI. The State has standards which include (check all that apply):

1.___ A policy making body which oversees the QAPI

2.___ A designated senior official responsible for program administration and documentation of Quality Improvement committee activities.

3.___ Active participation by providers and consumers

4.___ Ongoing communication and collaboration among the Quality Improvement policy making body and other functional areas of the organization.

5.___ Other (please describe):

b.___ Measure their performance, using standard measures established or adopted by the State Medicaid agency, and reports their performance to the

applicable agency. Please list or attach the standard measures currently required.

c.___ Achieve required minimum performance levels, as established by the State Medicaid agency on standardized quality measures. Please list or attach the standardized quality measures established by the State Medicaid agency.

d.___ Conduct performance improvement projects that achieve, through ongoing measurement and intervention, demonstrable and sustained improvement in significant aspects of clinical care and non-clinical services that can be expected to have a beneficial effect on health outcomes and enrollee satisfaction.

Please list the projects currently planned for each year of the waiver period either at a state or plan-level. Please describe the types of issues that are included in clinical (e.g., acute/chronic conditions, high-volume/high-risk services) and non-clinical (e.g., complaints, appeals, cultural competence, accessibility) focus areas as defined by the State.

e.___ Correct significant systemic problems that come to its attention through internal surveillance, complaints, or other mechanisms.

f.___ Are allowed to collaborate with one another on projects, subject to the approval of the State Medicaid agency.

g.___ Are allowed to conduct multi-year projects that meet the improvement standards as described in QISMC or that are specified in a project work plan developed in consultation with the State Medicaid agency.

h.___ Select topics for projects through continuous data collection and analysis by the organization of comprehensive aspects of patient care and member services.

i.___ Select and prioritize topics for projects to achieve the greatest practical benefit for enrollees.

j.___ Select topics in a way that takes into account the prevalence of a condition among, or need for a specific service by, the organization's enrollees; enrollee demographic characteristics and health risks; and the interest of consumers in the aspect of care or services to be addressed.

k.___ Provide opportunities for enrollees to participate in the selection of project topics and the formulation of project goals.

l.___ Assess and measure the organization's performance for each selected topic using one or more quality indicators.

m.__ Base the assessment of the organization's performance on systematic, ongoing collection and analysis of valid and reliable data.

n.___ Establish a baseline measure of performance on each indicator, measure changes in performance, and continue measurement of at least one year after a desired level of performance is achieved.

o.___ Use a sampling methodology that ensures that results are accurate and reflective of the MCOs/PHPs enrolled Medicaid population.

p.___ Meet previously-determined standards to define results that show significant demonstrable improvement in performance as evidenced in repeat measurements of the quality indicators specified for each performance improvement project identified.

q.___ Use benchmarks levels of performance which are either determined in advance by the State Medicaid agency or by the organization.

r.___ Ensure that improvement is reasonably attributable to interventions undertaken by the organization (has face validity).

s.___ Administer their QAPI through clear and appropriate administrative arrangements.

t.___ Formally evaluate, at least annually, the effectiveness of the QAPI strategy, and make necessary changes.

u.___ Other (please describe):

Section D. Cost Effectiveness

In order to demonstrate cost effectiveness, a waiver renewal request must demonstrate that it was cost-effective during the previous two-year waiver period (Years 1 and 2) and must show that the cost of the waiver program will not exceed what Medicaid costs would have been in the absence of the waiver in the upcoming two-year waiver period (Years 3 and 4).

With respect to waivers involving capitated reimbursement, a State's computation of its UPL (as required by 42 CFR 447.361) may serve the dual purpose of computing the projected Medicaid costs in the absence of the waiver as well. **The UPL is only one component of waiver cost effectiveness, which must also include comparisons of a State's administrative costs and relevant FFS costs with and without the waiver as well.**

HCFA offers the following suggestions to States in completing this section:

- States are strongly encouraged to use the revised waiver preprint format to reduce the number of questions regarding their cost-effectiveness calculations. Please note that use of the revised preprint is optional.

- Cost effectiveness for 1915(b) waivers is measured in total computable dollars (Federal and State share).

- States are not be held accountable for caseload changes when submitting their waiver renewal cost-effectiveness calculations for services. States should have Per Member Per Month (PMPM) costs for the 2-year period equal to or less than projected Without Waiver costs as calculated in Step 18 of Appendix D.IV of their initial preprint. **Please ensure that you are using the PMPM Without Waiver costs that were approved in the previous waiver in your renewal.** In addition, States will also not be held accountable for benefit package, payment rate, or other programmatic changes made to the waiver program.

- Waiver expenditures should be reported on the Quarterly Medicaid Statement of Expenditures (Form HCFA-64 Report), according to reporting instructions in the State Medicaid Manual, Section 2500. If the State has specific questions regarding this requirement, please contact your State's HCFA accountant in the Regional Office.

- A set of sample preprint Appendices has been included with this preprint using Year 2 of one State's experience (DSAMPLE.XLS). Blank Appendices have been included for your use (APPD.XLS). **Please modify the spreadsheets to meet your State's UPL and rate development techniques, using the State's capitated rate cells (most states use eligibility category, age, and gender-adjusted cells)**. If a waiver program does not cover all categories of service, the

State should modify the spreadsheet to include only covered services. Please submit the electronic spreadsheets used to create the Appendices to HCFA (HCFA currently uses Excel, which will convert both Lotus and QuatroPro). Please structure the worksheets as schedules which can link the totals between spreadsheets and roll up into a summary if the State has that capability. Linking the sheets and summaries will reduce copying from one schedule to another, which may introduce errors.

- The costs and enrollment numbers for voluntary populations (i.e., populations which can choose between joining managed care and staying in FFS) should be excluded from the waiver cost-effectiveness calculations if these individuals are not included in the waiver. In general, HCFA believes that voluntary populations should not be included in 1915(b) waivers (i.e., excluded in Section A.II.l and A.II.m). If the State wants to include voluntary populations in the waiver (i.e., listed in Section A.III.b.3), then the costs and enrollment numbers for the population must be included in the cost-effectiveness calculations. In addition, States that elect to include voluntary populations in the waiver are required to submit a written explanation of how selection bias will be addressed in the rate setting or with waiver calculations. HCFA may require the State to adjust its upper payment limits for the voluntary population to account for selection bias.

Description of the Cost-Effectiveness Calculation Process:
In general, the UPL for capitation contracts on a risk basis (e.g., MCO, HIO, or PHP) is the State agency's estimated cost of providing the scope of services covered by the capitation payment if these services were provided on a FFS basis. Documentation for the without waiver costs must be calculated on a per member per month basis.

- In order to determine cost-effectiveness, States must first document the number of member months participating in the waiver program for the previous waiver period (Year 1 and Year 2). They must then estimate the number of member months for the target population which will participate in the waiver program for the upcoming waiver period (Year 3 and Year 4) See Appendix D.II, Steps 1-4. The member months estimation should be based on the actual State eligibility data in the base year and the experience of the program in Year 1 and Year 2.

- The base year and the source of the without waiver data need to be identified for Years 1 - 4. The sources for this data and any adjustments to this data must be listed (Appendix D.III, Steps 5-9). If the State is proposing to use a different methodology for Years 3 and 4, please document all differences between the methodologies. Without Waiver Costs should be created using a FFS UPL based on FFS data with FFS utilization and FFS inflation assumptions. HCFA recommends that a State use at least three years of FFS Medicaid historical data to develop utilization and inflation trend rates.

- Statistically valid (as defined by the State's actuary) without waiver cost and

eligibility data for the population to be covered must be established. Base years should be specific to the eligibility group and locality covered by the contract and, to the extent possible, the costs included in the capitation rates. The exception to this would be where the size of the group is not sufficiently large to represent a statistically valid sample. These base year costs need to be broken down into each of the main service categories covered under the contract--inpatient hospital, outpatient hospital, physician, lab and x-ray, pharmacy, and other costs (Appendix D.IV, Steps 10-13).

- Once the base year costs are established, States need to make adjustments to that data in order to update it to the year to be covered by the capitation contract. These adjustments represent the impact on Medicaid costs from such things as inflation, utilization factors, administrative expenses, program changes, reinsurance or stop-loss limits, and third party liability. When these adjustments are computed and factored into the base year costs, the end result is a projected UPL for the year under contract (Appendix D.IV, Steps 14-16). The State then needs to consider the effect of costs which are outside the capitation rate (and therefore outside the UPL), but are affected by the capitated contractor. These services are generally referred to as wraparound services, and may include such services as pharmacy. Because the capitated contractor can affect the costs of these wraparound services, they must be included in the without waiver cost development (Appendix D.IV, Steps 17-18). Without waiver costs must be developed for all Years 1 - 4.

- States must document actual PMPM costs under the waiver for the previous two-year period. They also must estimate the PMPM costs under the upcoming waiver period. The costs should include services controlled by the waiver but not in the capitated rate, plus the agency's average per capita administrative costs related to these services (Appendix D.V, Steps 19-29).

- States must then calculate the aggregate costs without the waiver and the aggregate costs with the waiver (Appendices D.VI, D.VII, Steps 30-35).

- States must clearly demonstrate that, when compared, payments to the contractor did not exceed the UPL in the past two years and will not exceed the UPL in the future two years (Appendix D.VIII, Steps 36-37), and costs under the waiver did not exceed costs without the waiver costs in the previous period and will not exceed without waiver costs in the future (Appendix D.VIII, Steps 38-40).

Assurance (Please initial or check)

_____ The fiscal staff in the Medicaid agency has reviewed these calculations for accuracy and attests to their correctness.

Name of Medicaid Financial Officer:_____

Telephone Number:_____

The following questions are to be completed in conjunction with the Worksheet Appendices. We have incorporated step-by-step instructions directly into the worksheet using instruction boxes. Where further clarification was needed, we have included additional information in the preprint. All narrative explanations should be included in the preprint.

I. Type of Contract The response to this question should be the same as in **A.II.e**.

a.___ Risk-comprehensive (fully-capitated--MCOs, HIOs, or certain PHPs)

b.___ Other risk (partially-capitated--PHP)

c.___ Non-risk. Please use Section C of the PCCM initial application.

d.___ Other (please explain):

II. Member Months: Appendix D.II.

Purpose: To provide data on actual and projected enrollment during the waiver period. Actual enrollment data for the previous waiver period must be obtained from the State's tracking system. Projected enrollment data for the upcoming period is needed to determine whether the waiver is likely to be cost effective. This data is also useful in assessing future enrollment changes in the waiver.

Step 1: Please list the rate cells which were used in setting capitation rates under the waiver. The number and distribution of rate cells will vary by State. If the State used different cells in Years 1 & 2 than in Years 3 & 4, please create separate tables for the two waiver periods. The base year should be the same as the FFS data used to create the PMPM without waiver costs. Base year eligibility adjustments such as shifts in eligibility resulting in an increase or decrease in the number of member months enrolled in the program should be noted here. Note: because of the timing of the waiver renewal submittal, the State may need to estimate up to six (6) months of enrollment data for Year 2 of the previous waiver period.

Step 2: See instruction box. If the State estimates that all eligible individuals will not be enrolled in managed care (i.e., a percentage of individuals will be unenrolled because of eligibility changes and the length of the enrollment process) please note the adjustment here.

Step 3: See instruction box. In the space provided below, please explain any variance in member months, by region, from Year 1 to Year 4.

Step 4: See instruction box. In the space provided below, please explain any variance in total member months from Year 1 to Year 4.

a. Population in base year data

1.___ Base year data is from the same population as to be included in the waiver.

2. __ Base year data is from a comparable population to the individuals to be included in the waiver. (Include a statement from an actuary or other explanation which supports the conclusion that the populations are comparable.)

III. Without Waiver Data Sources and Adjustments: Appendix D.III.

Purpose: To explain the data sources and reimbursement methodology for base year costs.

To identify adjustments which must be made to base year costs in order to arrive at the UPL for capitated services and the without waiver costs for all waiver services.

NOTE: The data on this schedule will be used in preparing **Appendix D.IV Without Waiver Cost Development**. Also, it is acceptable to use encounter data or managed care experience to develop with waiver costs or set capitated rates (see Section D.V). At this time, it is not acceptable to use experience data to develop without waiver costs. A workgroup has been formed to examine this policy. This submittal will be updated based upon the outcome of that workgroup.

NOTE: If the State is proposing to use a different methodology for Years 3 and 4 than were used in Years 1 and 2, please document all differences between the methodologies.

Regional Offices approve annual UPLs and contract rates developed by States. They are authorized to approve UPLs and contract rates that fall under the methodologies granted under the original and subsequent waiver authority. Modifications to the UPL development methodology should be approved through a waiver modification as explained in the instructions to this submittal.

Step 5: Actual cost and eligibility data are required for base year PMPM computations. Specify whether the base year is a State fiscal year (SFY), Federal fiscal year (FFY), or other period. **Please note the waiver years that this methodology was in place. Submit separate Appendix D.III charts if different methodologies or**

services were used in the Without Waiver costs for the upcoming waiver period than in the previous waiver period. Please provide an explanation in the space below if: a) multiple years are used as the base year; or b) data from sources other than the State's MMIS are used.

Step 6: See instruction box. This chart should be identical to the chart in Section A.III.d.1.

Step 7: **UPL Adjustments:** On Appendix D.III check all adjustments that apply to base year data.

Step 8. **Fee-For-Service Wraparound Cost Adjustments**: See instruction box.

Instructions For Steps 7 and 8 above:

Required Adjustments a. through g. (below) and Appendix D.III must be completed by all States. Optional Adjustments a. through l. (below) should be completed if the adjustment applies to your State. For each Optional Adjustment that does not apply, the State should note if they have made a policy decision to not include that adjustment. If the State has made an adjustment to its without waiver cost, information on the basis and methodology information below must be completed and mathematically accounted for in Appendix D.IV. All adjustments may be computed on a statewide basis, although some (e.g. reinsurance, stop/loss) may be specific to certain contracts and should be noted where appropriate. Similarly, some adjustments will apply to all services and to all eligibility categories while others will only apply to specific services provided to distinct eligibility categories. Again, it is very important to complete this preprint and Appendices D.III and D.IV as necessary to account for the proper methodology used by the State to calculate the UPL.

Describe below the methodology used to develop each adjustment. Prior approval is necessary for methodologies that are not listed as an optional check-off. Please note on each adjustment if the methodology is proprietary to the actuary. Note: HCFA's intent is that if an accepted methodology is used (i.e., is one of the check-offs) and the size of the adjustment is noted in the Appendices and appears reasonable, then no additional documentation would be required for the waiver application. However, the HCFA RO may require more documentation during the UPL and contract rate approval process.

Please note the waiver years that each adjustment was in place if the adjustment was not made for all four years. Submit separate Appendix D.IV charts for each year in the Without Waiver costs for the previous and upcoming waiver period.

Previous Waiver Period

a.___ During the last waiver period, the methodology used to calculate cost-effectiveness was different than described in the waiver governing that period. The differences were:

Please note the date of any methodology change and explain any methodology changes in this preprint. See also Step 5.

Upcoming Waiver Period -- For all three subsets of adjustments (Without Waiver Response required, Optional, and With Waiver Cost Adjustments) in this section, please identify any responses that reflect a change in program from the previous waiver submittal(s) by placing two asterisks (i.e., "**") after your response.

State Response to These Adjustments Is Required

a. Disproportionate Share Hospital (DSH) Payments: Section 4721 of the BBA specifies that DSH payments must be made solely to hospitals and not to MCOs/PHPs. Therefore, DSH payments are not to be included in cost-effectiveness calculations. Section 4721(c) does permit an exemption to the direct DSH payment. If this exemption applies to the State, please identify and describe in the Other Block.

1.___ We assure HCFA that DSH payments are excluded from base year data.
2.___ We assure HCFA that DSH payments are excluded from adjustments.
3.___ Other (please describe):

b. Incurred but not Reported (IBNR) (Appendix D.III, Line 47): Due to the lag between dates of service and dates of payment, completion factors must be applied to data to ensure that the base data represents all claims incurred during the base year. The IBNR factor increases the reported totals to an estimate of their ultimate value after all claims have been reported. Use of at least three years is recommended as a basis.

Basis:

1.___ IBNR adjustment was made. Please indicate the number of years used as basis _____.
   i.___ Claims in base year data source are based on date of service.
   ii.___ Claims in base year data source are based on date of payment.

2.___ IBNR adjustment was not necessary (Please explain).

Methodology:

1.___ Calculate average monthly completion factors and apply to the known paid total to derive an overall completion percentage for the base period.
2.___ Other (please describe):

c. Inflation (Appendix D.III, Line 48): This adjustment reflects the expected inflation in the FFS program between the Base Year and Year One and Two of the waiver. Inflation adjustments may be service-specific and expressed as percentage factors. States should use State historical FFS inflation rates.
Basis:

1.___ State historical inflation rates
   (a) Please indicate the years on which the rates are based: Inflation base years_____
   (b) Please indicate the mathematical methodology used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.):

2.___ Other (please describe):

d. Third Party Liability(TPL) (Appendix D.III, Line 61): This adjustment should be used only if the State will not collect and keep TPL payments for post-pay recoveries. If the MCO/PHP will collect and keep TPL, then the Base Year costs should be reduced by the amount to be collected.
Basis and methodology:

1.___ No adjustment was necessary
2.___ Medicaid Management Information System (MMIS) claims tapes for UPL and rate development were cut with post-pay recoveries already deducted from the database.
3.___ State collects TPL on behalf of MCO/PHP enrollees
4.___ The State made this adjustment:
5.___ Post-pay recoveries were estimated and the base year costs were reduced by the amount of TPL to be collected by MCOs/PHPs.
6.___ Other (please describe):

e. FQHC and RHC Cost-Settlement Adjustment (Appendix D.III, Line 46) : This adjustment accounts for the requirement of States to make supplemental payments for the difference between the rates paid by an MCO/PHP to an FQHC or RHC and the reasonable costs of the FQHC or RHC. The UPL and capitated rates should include payments for comparable non-FQHC or non-RHC primary care service expenditures.

1.___ Cost-settlement supplemental payments made to FQHCs/RHCs are included in without waiver costs, but not included in the MCO/PHP rates, base year UPL costs, or adjustments. The State also accounted for any phase-down in FQHC/RHC payments beginning in Fiscal Year 2000, as outlined by Section 4712 of the BBA. If the State pays a percentage of cost-settlement different than outlined in the BBA not to exceed 100 percent, please list the percentage paid _____. The UPL and capitated rates should include payments for

comparable non-FQHC or non-RHC primary care service expenditures.

2.___ Other (please describe):

f. Payments / Recoupments not Processed through MMIS (Appendix D.III, Line 51): Any payments or recoupments for covered Medicaid State Plan services included in the waiver but processed outside of the MMIS system should be included in the UPL.

1.___ Payments outside of the MMIS were made. Those payments include (please describe):

2.___ Recoupments outside of the MMIS were made. Those recoupments include (please describe):

3.___ The State had no recoupments/payments outside of the MMIS.

g. Pharmacy Rebate Factor (Appendix D.III, Line 68): Rebates that States receive from drug manufacturers should be deducted from UPL base year costs if pharmacy services are included in the capitated base. If the base year costs are not reduced by the rebate factor, an inflated UPL may result. Pharmacy rebates should also be deducted from FFS costs if pharmacy services are under the waiver but not capitated.

Basis and Methodology:

1.___ Determine the percentage of Medicaid pharmacy costs that the rebates represent and adjust the base year costs by this percentage. States may want to make separate adjustments for prescription versus over the counter drugs and for different rebate percentages by population. States may assume that the rebates for the targeted population occur in the same proportion as the rebates for the total Medicaid population.

2.___ The State has not made this adjustment because pharmacy is not an included capitation service and the capitated contractor's providers do not prescribe drugs that are paid for by the State in FFS.

3.___ Other (please describe):

Optional Adjustments

Note: These adjustments may be made based upon the State's own policy preferences. There is no HCFA preference for any of these adjustments. If the State has made an adjustment to its without waiver cost, information on the basis and methodology used is required and must be mathematically accounted for in Appendix D.IV. If the State has chosen not to make these adjustments, please mark the appropriate box.

a. Administrative Cost Calculation(Appendix D.III, Line 44): The administrative expense factor should include administrative costs that would have been attributed to members participating in the MCO/PHP if these members had been enrolled in FFS. Only those costs for which the State is no longer

responsible should be recognized. Examples of these costs include per claim claims processing costs, additional per record PRO review costs, and additional Surveillance and Utilization Review System (SURS) volume costs.
Basis:

1.___ All estimated administrative costs of the FFS plan that would be associated with enrolled managed care members if they had been enrolled in the FFS delivery system in this adjustment. This is equal to ___ percent of FFS service costs.
2.___ The State has chosen not to make adjustment.
3.___ Other (please describe):

Methodology:

1.___ Determine administrative costs on a PMPM basis by adding all FFS administrative costs and dividing by number of total Medicaid FFS members
2.___ Determine the percentage of medical costs that are administrative and apply this percentage to each rate cell.
3.___ Other (please describe):

b. Copayment Adjustment (Appendix D.III, Line 45): This adjustment accounts for any copayments that are collected under the FFS program but not to be collected in the capitated program. States must ensure that these copayments are included in the UPL if not to be collected in the capitated program.
Basis and Methodology:

1.___ Claims data used for UPL development already included copayments and no adjustment was necessary.
2.___ State added estimated amounts of copayments for these services in FFS that were not in the capitated program.
3.___ The State has chosen not to make adjustment.
4.___ Other (please describe):

c. Data Smoothing Calculations for Predictability (Appendix D.III, Line 65): Costs in rate cells are smoothed through a cost-neutral process to reduce distortions across cells and adjust rates toward the statewide average rate. These distortions are primarily the result of small populations, access problems in certain areas of the State, or extremely high cost catastrophic claims.
Basis and Methodology

1.___ The State made this adjustment (please describe):

2.___ The State has chosen not to make adjustment.

d. Investment Income Factor (Appendix D.III, Line 50): This factor adjusts

capitation rates and UPLs because FFS claims are paid after a service is provided while payments under managed care are made before the time of services.

1.___ Since payments are made earlier, the equivalent amount of payment is slightly less, because the earlier payments would generate investment income between the date of receipts and the date of claim payment. A small reduction to the UPL was made. Factors to take into account include payment lags by type of provider; advances to providers; and the timing of payments to prepaid plans, relative to when services are provided.

2.___ The State has chosen not to make adjustment.

3.___ Other (please describe):

e. PCCM case-management fee deduction (Appendix D.III, Line 52): When States transition from a PCCM program to a capitated program and use the PCCM claims data to create capitated UPLs, any management fees paid to the PCCM must be deducted from the UPL.

1.___ PCCM claims data were used to create capitated UPLs and management fees were deducted. Please note: if the State chose to use PCCM claims data, then this adjustment is required.

2.___ This adjustment was not necessary because the State used MMIS claims exclusive of any PCCM case-management fees.

3.___ Other (please describe):

f. Pooling for Catastrophic Claims (Appendix D.III, Line 53): This adjustment should be used if it is determined that a small number of catastrophic claims are distorting per capita costs in some rate cells and are not predictive of future utilization.

Methodology:

1.___ The high cost cases' costs are removed from the rate cells and the per capita claim costs are distributed statewide across a relevant grouping of capitation payment cells. No costs are removed entirely from the rate cells, merely redistributed to rate cells in a manner that is more predictive of future utilization.

2.___ The State has chosen not to make adjustment.

3.___ Other (please describe):

g. Pricing (Appendix D.III, Line 54): These adjustments account for changes in the cost of services under FFS. For example, changes in fee schedules, changes brought about by legal action, or changes brought about by legislation.

Basis:

1.___ Expected State Medicaid FFS fee schedule increases between the base and rate periods.
2.___ The State has chosen not to make FFS price increases in the managed care rates.
3.___ Changes brought about by legal action (please describe):
4.___ Changes in legislation (please describe):
5.___ Other (please describe):

h. Programmatic/policy changes (Appendix D.III, Line 55): These adjustments should account for any FFS programmatic changes that are not cost neutral and affect the UPL. For example, Federal mandates, changes in hospital payment from per diem rates to Diagnostic Related Group (DRG) rates or changes in the benefit coverage of the FFS program.

Basis and Methodology:

1.___ The State made this adjustment (please describe).
2.___ The State has chosen not to make adjustment because there were no programmatic or policy changes in the FFS program after the MMIS claims tape was created. In addition, the State anticipates no programmatic or policy changes during the waiver period.

i. Regional Factors applied to Small Populations (Appendix D.III, Line 59): This adjustment is to be applied when there are a small number of eligible months in certain rate cells and large variations in PMPMs across these categories and regions exist.

Methodology:

1.___ Regional factors based on eligible months are developed and then applied to statewide PMPM costs in rate cells for small populations. This technique smooths out wide fluctuations in individual rate cells in rural states and some populations, yet ensures that expenditures remain budget neutral for each region and State.
2.___ The State has chosen not to make adjustment.
3.___ Other (please describe):

j. Retrospective Eligibility (Appendix D.III, Line 60): States that have allowed retrospective eligibility under FFS must ensure that the costs of providing retrospective eligibility are not included in the UPL. The rationale for this is that MCOs/PHPs will not incur costs associated with retrospective eligibility because capitated eligibility is prospective. Please note, however, that newborns need not be removed from the base year costs if the State provides retrospective

eligibility back to birth for newborns.
Basis and Methodology:

1.___ Compare the date that the enrollee was determined Medicaid-eligible by the State to the date at which Medicaid-eligibility became effective. If the effective date is earlier than the eligibility date, then the costs for retrospective eligibility were removed.
2.___ The State has chosen not to make adjustment because it was not necessary given the State's enrollment process.
3.___ Other (please describe):

k. Utilization (Appendix D.III, Line 62): This adjustment reflects the changes in utilization of FFS services between the Base Year and the beginning of the waiver and between Years One and Two of the waiver.

1.___ The State estimated the changes in technology and/or practice patterns that would occur in FFS delivery, regardless of capitation. Utilization adjustments made were service-specific and expressed as percentage factors.
2.___ The State has chosen not to make adjustment.
3.___ Other (please describe):

l. Other Adjustments including but not limited to guaranteed eligibility and risk-adjustment (Appendix D.III, Line 63). If the State enrolls persons with special health care needs, please explain by population any payment methodology adjustments made by the State for each population. For example, HCFA expects States to set rates for each eligibility category (i.e., the State should set UPLs and rates separately for TANF, SSI, and Foster Care Children). Please list and describe the basis and methodology:

Step 9: **With Waiver Cost Adjustments** (in addition to the Capitated or FFS Base Year Cost Adjustments), Appendix D.III, Lines 70-72). Note: Costs for the following adjustments are included in the With Waiver Costs Appendix D.V.

a. Reinsurance or Stop/Loss Coverage (Appendix D.III, Line 71): Please note whether or not the State will be providing reinsurance or stop/loss coverage. Reinsurance may be provided by States to MCOs/PHPs when MCOs/PHPs exceed certain payment thresholds for individual enrollees. Stop loss provisions usually set limits on maximum days of coverage or number of services for which the MCO/PHP will be responsible. If the State plans to implement either reinsurance or stop/loss, a description of the methodology used is required. The State must document the probability of incurring costs in excess of the stop/loss level and the frequency of such occurrence based

on FFS experience. The rate of expenses per capita should be deducted from the capitation year projected costs. In the initial application, the effect should be neutral. In the renewal report, the actual reinsurance cost and claims cost should be reported in with waiver costs.
Basis and Methodology:

1.___ The State does not provide reinsurance or stop/loss for MCOs/PHPs, but requires MCOs/PHP to purchase such coverage privately. No adjustment was necessary.

2.___ The State provides reinsurance or stop/loss (please describe):

b. Incentive/bonus payments (Appendix D.III, Line 72): This adjustment should be applied if the State elects to provide incentive payments in addition to capitated payments under the waiver program. The State must document the criteria for awarding the incentive payments, the methodology for calculating incentives/bonuses, and the monitoring the State will have in place to ensure that total payments to the MCOs/PHPs do not exceed the UPL. The costs associated with any bonus arrangements must be accounted for in Appendix D.V With Waiver costs.
Please describe the criteria for awarding incentive payments, the methodology for calculating bonus amounts, and the monitoring the State will have in place to ensure that total payments to MCOs/PHPs do not exceed the UPL:

c. Other Adjustments (Please list and describe the basis and methodology):

IV. Without Waiver Development: Appendix D.IV

Purpose: To calculate without waiver costs on a PMPM basis.

NOTE: HCFA will measure the cost effectiveness of the waiver in the renewal based on this PMPM calculation and the actual enrollment under the waiver.

Please note that the data in this section for Waiver Years 1 and 2 should reflect the PMPM Without Waiver costs that were approved in the previous waiver in your renewal, plus any changes approved by the RO in the annual capitated rate approval. Please submit separate Appendix D.IV charts for each year in the Without Waiver costs for the previous and upcoming waiver period.

Step 10: See instruction box.

Step 11: See instruction box. These rate cells must be identical to the rate cells used in Appendix D.II Member Months.

Steps 12-13: See instruction boxes.

Step 14: See instruction box. Adjustments expressed as percentages are applied to the base year amount by category of service.

Steps 15-16: See instruction boxes.

Step 17: See instruction box. Step 17 is designed to incorporate the cost of FFS wraparound services into the without waiver costs. To simplify presentation, the State may combine all wraparound services listed at Appendix D.III, presenting them as one base year amount per rate cell. The State may then combine all adjustment factors which affect a given rate cell, and apply the adjustments accordingly. This methodology will result in a subtotal of adjusted FFS costs applied to each rate cell. If the State prefers, individual FFS wraparound services may be calculated on Appendix D.IV, as illustrated with pharmacy services in the example (Columns Z-AF). If adjusted FFS costs are material, the State should be prepared to explain the adjustments upon request.

Step 18: See instruction box. These amounts represent the final PMPM amounts which will be applied to actual enrollment in measuring cost effectiveness. States will not be held accountable for caseload changes when submitting their waiver renewal cost-effectiveness calculations. States should have PMPM costs for the 2-year period equal to or less than projected Without Waiver costs as calculated in Step 18.

V. With Waiver Development: Appendix D.V

Steps 19-29

The actuarial basis for the capitation rates for both MCOs and PHPs must be specified in the waiver application, and there must be a demonstration that payments to the contractor will be on an actuarially sound basis, in accordance with the regulations at 42 CFR 434.61. The capitation rates must be specified in the waiver application. Specifying the "actuarial basis" of the capitation rate means providing a description of the methodology the State uses to determine its capitation rate(s). Among the possible methods a State might use are: a percentage of the UPL; a budget-based rate (e.g., the MCO/PHP's cost); and the contractor's community rate with adjustments as appropriate (e.g., for the scope of services in the State's contract and the utilization characteristics of the Medicaid enrollees).

You may use other methods as well. If there are adjustments for stop-loss and

reinsurance arrangements, the actuarial basis for these adjustments should be documented. The important things to remember are that the rate methodology must be specified and there must be a demonstration that the rates do not exceed the UPL.

Finally, as specified in 42 CFR 447.361, payments to contractors must be no more than the cost of providing those same services on a FFS basis, to an actuarially equivalent nonenrolled population group (i.e., no greater than the UPL).

With waiver costs are the sum of payments to capitated providers, FFS payments for managed care enrollees that are controlled or affected by managed care providers, and the costs to the State of implementing and maintaining the managed care program.

a. Please mark and complete the following assurances to HCFA:

1.___ The State assures HCFA that the capitated rates will be equal to or less than the UPL based upon the following methodology. Please attach a description of the rate setting methodology and how the State will ensure that rates are less than the UPL if the State is not setting rates at a percent of UPL.
(a)__ Rates are set at a percent of UPL
(b)__ Negotiation (please describe):
(c)__ Experience-based (contractor/State's cost experience or encounter data) (please describe):
(d)__ Adjusted Community Rate (please describe):
(e)__ Other (please describe):

2.___ The rates were set in an actuarially sound manner. Please list the name, organizational affiliation of the actuary used, and actuarial attestation of the initial capitation rates.

_____

3.___ The State will submit all capitated rates to the HCFA RO for prior approval.

b.___ The State is requesting a 1915(b)(3) waiver in section A.II.g.2 and will be providing non-state plan medical services.

1.___ The State will be spending a portion of its savings above the capitation rates for additional services under the waiver.

Please state the actual amounts spent on 1915(b)(3) savings which was spent on additional services in the previous waiver period_____. This amount must be built into the State's

with waiver costs for Years 1 and 2.

Please state the PMPM or aggregate amount of 1915(b)(3) savings which will be spent on additional services in the upcoming waiver period_____. This amount must be built into the State's with waiver costs for Years 3 and 4.

2.___ The State is requiring plans to spend a portion of their capitated rate on additional non-State plan medical services.

Please state the actual amount or percent of the PMPM that was spent on average on non-State plan covered medical services_____. This amount must be built into the State's with waiver costs as a portion of the capitated rates. Please document the actual amount spent on non-State plan medical services.

Please estimate the amount or percent of the PMPMs that will be spent on average on non-State plan covered medical services_____. This amount must be built into the State's with waiver costs as a portion of the capitated rates. Please explain the assumptions that the State used to calculate this amount.

Steps 19-20: See instruction boxes. The eligibility categories and rate cells must agree with those in Appendix D.IV. States must document actual PMPM costs under the waiver for the previous two-year period. They also must estimate the PMPM costs under the upcoming waiver period. **Please note that the data in this section for Waiver Years 1 and 2 should reflect the actual costs incurred in the previous waiver period under the Waiver Program. Please submit separate Appendix D.IV charts for each year in the Without Waiver costs for the previous and upcoming waiver period.** Note: because of the timing of the waiver renewal submittal, the State may need to estimate up to six (6) months of enrollment data for Year 2 of the previous waiver period.

Steps 21-29: See instruction boxes.

VI. Year 1 Aggregate Costs: Appendix D.VI
See Instructions for C.VII Year 2 Aggregate Costs

VII. Year 2 Aggregate Costs: **Appendix D.VII**
Steps 30-35: See instruction boxes.

VIII. Year 3 Aggregate Costs: **Appendix D.VIII**
See Instructions for C.VII Year 2 Aggregate Costs

IX. Year 4 Aggregate Costs: **Appendix D.IX**
See Instructions for C.VII Year 2 Aggregate Costs

X. Cost Effectiveness Summary: Appendix D.X
Steps 36-40: See instruction boxes.

Section E. Fraud and Abuse

States can promote the prevention, detection, and reporting of fraud and abuse in managed care by ensuring both the State and the MCOs/PHPs have certain provisions in place.

Previous Waiver Period

a.___ During the last waiver period, the program's fraud and abuse requirements operated differently than described in the waiver governing that period. The differences were:

b. [Required for all elements checked in the previous waiver submittal] Please provide summary results from all fraud and abuse monitoring activities, including a summary of any analysis and corrective action taken, for the previous waiver period [items E.I-II of 1999 initial preprint; relevant sections of 1995 preprint].

Upcoming Waiver Period -- Please check all items below which apply, and describe any other measures the State takes. For all items in this section, please identify any responses that reflect a change in program from the previous waiver submittal(s) by placing two asterisks (i.e., "**") after your response.

I. State Mechanisms

a.___ The State has systems to avoid duplicate payments (e.g., denial of claims for services which are the responsibility of the MCO/PHP, by the State's claims processing system).

b.___ The State has a system for reporting costs for non-capitation payments made in addition to capitation payments (e.g., where State offered reinsurance or a stop/loss limit results in FFS costs for enrollees exceeding specified limits)

c.___ The State has in place a formal plan for preventing, detecting, pursuing, and reporting fraud and abuse in the managed care program in this waiver, which identifies the staff, systems, and other resources devoted to this effort. Please attach the fraud and abuse plan.

d.___ The State has a specific process for informing MCOs/PHPs of fraud and abuse requirements under this waiver. If so, please describe.

e.___ Other (please describe):

II. MCO/PHP Fraud Provisions

a.___ The State requires MCOs/PHPs to have an internal plan for preventing, detecting, and pursuing fraud and abuse. Please describe any required fraud and abuse plan elements.

b.___ The State requires MCOs/PHPs to report suspected fraud and cooperate with State (including Medicaid Fraud Control Unit) investigations.

Section F. Special Populations

States may wish to refer to the October 1998 HCFA document entitled "Key Approaches To The Use of Managed Care Systems For Persons With Special Health Care Needs" as guidance for efforts to ensure access and availability of services for persons with special needs. To a certain extent, key elements of that guide have been incorporated into this waiver application form.

I. General Provisions for Special Populations

Previous Waiver Period

a.___ During the last waiver period, the program operated differently for special populations than described in the waiver governing that period. The differences were:

b. [Required for all elements of applicable sections checked in the previous waiver submittal] Please provide results from all monitoring efforts for each subpopulation noted in the previous waiver, including a summary of any analysis and corrective action taken, to determine the level of compliance with State requirements in the area of special populations for the previous waiver period [items F.I.a-g of the 1999 initial preprint; as applicable in 1995 preprint].

c. Please describe the transition plan for situations where an enrollee with special health care needs will be assigned to a new provider when the current provider is not included in the provider network under the waiver.

Upcoming Waiver Period -- For items a. through g. of this section, please identify any responses that reflect a change in program from the previous waiver submittal(s) by placing two asterisks (i.e., "**") after your response. Please check all items which apply to the State.

a.___ The State has a specific definition of "special populations" or "populations with special health care needs." The definition should include populations beyond those who are SSI or SSI-related, if appropriate, such as persons with serious and persistent mental illness, and should specify whether they include adults and/or children. Some examples include: Children with special needs due to physical and/ or mental illnesses, Older adults (over 65), Foster care children, Homeless individuals, Individuals with serious and persistent mental illness and/or substance abuse, Non-elderly adults who are disabled or chronically ill with developmental or physical disability, or other. Please describe.

b.___ There are special populations included in this waiver program. Please list the populations.

c.___ The State has developed and implemented processes to collaborate and coordinate with, on an ongoing basis, agencies which serve special needs clients, advocates for special needs populations, special needs beneficiaries and their families. If checked, please briefly describe.

d. The State has programs/services in place which coordinate and offer additional resources and processes to ensure coordination of care among:

1.___ Other systems of care (Please specify, e.g. Medicare, HRSA Title V grants, Ryan White CARE Act, SAMHSA Mental Health and Substance Abuse Block Grant Funds)
2.___ State/local funding sources
3.___ Other (please describe):

e.___ The State has in place a process for ongoing monitoring of its listed special populations by special needs subpopulation included in the waiver in the following areas:

1.___ Access to services (please describe):
2.___ Quality of Care (please describe):
3.___ Coordination of care (please describe):
4.___ Enrollee satisfaction (please describe):
5.___ Other (please describe):

f.___ The State has standards or efforts under way regarding a location's physical Americans with Disabilities Act (ADA) access compliance for enrollees with physical disabilities. Please briefly describe these efforts, and how often compliance is monitored.

g.___ The State has specific performance measures and performance improvement projects for their populations with special health care needs. Please identify the measures and improvement projects by each population. Please list or attach the standard performance measures and performance improvement projects:

II. State Requirements for MCOs/PHPs

Previous Waiver Period

a.___ During the last waiver period, the program operated differently for special populations than described in the waiver governing that period. The differences were:

b. [Required for all elements checked in the previous waiver submittal] Please provide results from all monitoring efforts for each subpopulation noted in the previous waiver, including a summary of any analysis and corrective action taken, to determine the level of compliance with State requirements in the area of special populations for the previous waiver period [items F.II.a-h of the 1999 initial preprint; as applicable in 1995 preprint].

Upcoming Waiver Period For items a. through h. of this section, please identify any responses that reflect a change in program from the previous waiver submittal(s) by placing two asterisks (i.e., "**") after your response. Please check all the items which apply to the State or MCO/PHP.

a.___ The State has required care coordination/case management services the MCO/PHP shall provide for individuals with special health care needs. Please describe by population.

b.___ As part of its criteria for contracting with an MCO/PHP, the State assesses the MCO/PHP's skill and experience level in accommodating people with special needs. Please describe by population.

c.___ The State requires MCOs/PHPs to either contract or create arrangements with providers who have traditionally served people with special needs, for example, Ryan White providers and agencies

which provide care to homeless individuals. If checked, please describe by population.

d.___ The State has provisions in contracts with MCOs/PHPs which allow beneficiaries who utilize specialists frequently for their health care to be allowed to maintain these types of specialists as PCPs. If **not** checked, please explain by population.

e.___ The State collects or requires MCOs/PHPs to collect population-specific data for special populations. Please describe by population.

f.___ The State requires MCOs/PHPs that enroll people with special health care needs to provide special services, have unique medical necessity definitions and/or have unique service authorization policies and procedures.

1. Please note any services marked in the table in Section A.III.d.1 that are for special needs populations only by population.

2. Please note for Section C.II.b any unique definitions of "medically necessary services" for special needs populations by population.

3. Please note for Section C.II.d any unique written policies and procedures for service authorizations for special needs populations by population. For example, are MCOs required to coordinate referrals and authorizations of services with the State's Title V agency for any special needs children who qualify for Title V assistance.

g.___ The State requires MCOs/PHPs to identify individuals with complex or serious medical conditions in the following ways:

1.___ An initial and/or ongoing assessment of those conditions
2.___ The identification of medical procedures to address and/or monitor the conditions.
3.___ A treatment plan appropriate to those conditions that specifies an adequate number of direct access visits to specialists to accommodate implementation of the treatment plan.
4.___ Other (please describe):

h.___ The State specifies requirements of the MCO/PHPs for the special

populations in the waiver that differ from those requirements described in previous sections and earlier in this section of the application. Please describe by population.

Addendum to Section F:
Draft Interim Review Criteria for Children with Special Needs from June 4, 1999

This addendum is required if the State mandatorily enrolls children with special needs in any of these five subsets:

1. Blind/Disabled Children and Related Populations (eligible for SSI under title XVI);
2. Eligible under section 1902(e)(3) of the Social Security Act;
3. In foster care or other out-of-home placement;
4. Receiving foster care or adoption assistance; or
5. Receiving services through a family-centered, community-based coordinated care system that receives grant funds under section 501(a)(1)(D) of title V, as is defined by the State in terms of either program participant or special health care needs.

When addressing these criteria in your written descriptions, please provide the following information by each appropriate subset of children with special needs:

- The State's responsibilities in managed care programs enrolling children with special needs.
- The State's requirements for MCOs/PHPs enrolling children with special health care needs.
- How the State monitors its own actions and that of its contracting MCOs and PHPs.
- For foster-care children only, the provisions which address the broader, unique issues occurring because of out-of-home, out-of-geographic area placement.

I. State Responsibilities for Managed Care Programs Enrolling Children with Special Needs

a.___ Public Process [Required if the State mandatorily enrolls any of the children with special needs listed above] The State has in place a public process for the involvement of relevant parties (e.g., advocates, providers, consumer groups) during the development of the waiver program and has sought their participation in that process. Please describe *(Your description may refer to your waiver responses in Section A.I)*.

b.___ Definition of Children with Special Needs [Required if the State mandatorily enrolls any of the children with special needs listed above] The State has a definition of children with special needs that includes at least these five subsets:

1.___ Blind/Disabled Children and Related Populations (eligible for SSI

under title XVI);
2.___ Eligible under section 1902(e)(3) of the Social Security Act;
3.___ In foster care or other out-of-home placement;
4.___ Receiving foster care or adoption assistance; or
5.___ Receiving services through a family-centered, community-based coordinated care system that receives grant funds under section 501(a)(1)(D) of title V, as is defined by the State in terms of either program participant or special health care needs.
6.___ Other (please describe – *your description may refer to your description in Section F.I.a*).

c.___ Identification [Required if the State mandatorily enrolls any of the children with special needs listed above] The State identifies and/or requires MCOs/PHPs to identify children with special needs. The State collects, or requires MCOs/PHPs to collect specific data on children with special needs. The State explains the processes it has for identifying each of the special needs groups described above. Please describe.

d.___ Enrollment/Disenrollment [Required if the State mandatorily enrolls any of the children with special needs listed above] The State performs functions in the enrollment/disenrollment process for children with special needs, including:

1.___ [Required if the State mandatorily enrolls any of the children with special needs listed above] Outreach activities to reach potential children with special needs and their families, providers, and other interested parties regarding the managed care program. Please describe *(Your description may refer to your response in Section A.III.b.1)*.

2.___ [Required if the State mandatorily enrolls any of the children with special needs listed above] Enrollment selection counselors have information and training to assist special populations and children with special health care needs in selecting appropriate MCO/PHPs and providers based on their medical needs. Please describe *(Your description may refer to your response in Section A.III.b.4.b)*.

3. ___ [Required if the State mandatorily enrolls any of the children with special needs listed above] Auto-assignment process assigns children with special health care needs to an MCO/PHP that includes their current provider or to an MCO/PHP that is capable of serving their particular needs. Please describe *(Your description may refer to*

your response in Section A.III.b.4.g).

4.___ [Required if the State mandatorily enrolls any of the children with special needs listed above] A child with special needs can disenroll and re-enroll in another MCO/PHP for good cause. Please describe *(Your description may refer to your response in Section A.III.b.5.d.iii)*.

5.___ [Required if the State mandatorily enrolls any of the children with special needs listed above] If an MCO/PHP requests to disenroll or transfer enrollment of an enrollee to another plan, the reasons for reassignment are not discriminatory in any way -- including adverse change in an enrollee's health status and non-compliant behavior for individuals with mental health and substance abuse diagnoses -- against the enrollee. Please describe *(Your description may refer to your response in Section A.III.b.6.a)*.

e.___ Provider Capacity [Required if the State mandatorily enrolls any of the children with special needs listed above] The State performs functions in the monitoring provider capacity for children with special needs, including:

1.___ [Required if the State mandatorily enrolls any of the children with special needs listed above]The State ensures that the MCOs/PHPs in a geographic area have sufficient experienced providers to serve the enrolled children with special needs (e.g., providers experienced in serving foster care children, children with mental health care needs, children with HIV/AIDS, etc.). Please describe *(Your description may include reference to portions of your response in Section B.III.)*.

2.___ [Required if the State mandatorily enrolls any of the children with special needs listed above]The State monitors experienced providers capacity. Please describe *(Your description may include reference to portions of your response in Section B.III.)*.

f.___ Specialists [Required if the State mandatorily enrolls any of the children with special needs listed above] The State performs functions in the monitoring specialist capacity, including:

1.___ [Required if the State mandatorily enrolls any of the children with special needs listed above] The State has set capacity standards for specialists. Please describe *(Your description may refer to your*

response in Section B.III.c).

2.___ [Required if the State mandatorily enrolls any of the children with special needs listed above] The State monitors access to specialists. Please describe. *(Your description may refer to your responses in Section B.IV)*.

3.___ [Required if the State mandatorily enrolls any of the children with special needs listed above] The State has provisions in MCOs'/PHPs' contracts which allow children with special needs who utilize specialists frequently for their health care to be allowed to maintain these types of specialists as PCPs or be allowed direct access to specialists for the needed care. Please describe *(Your description may refer to your response in Section F.II.d)*.

4.___ [Required if the State mandatorily enrolls any of the children with special needs listed above] The State requires particular specialist types to be included in the MCO/PHP network. If specialists types are not involved in the MCO/PHP network, arrangements are made for enrollees to access these services (for waiver covered services only). Please describe *(Your description may refer to your responses in Section B.III.c)*.

g.___ Coordination [Required if the State mandatorily enrolls any of the children with special needs listed above] The State performs functions in the monitoring coordination of care for children with special needs, including:

1.___ [Required if the State mandatorily enrolls any of the children with special needs listed above] The State requires an assessment of each child's needs and implementation of a treatment plan based on that assessment. Please describe *(Your description may refer to your response in Section F.II.g)*.

2.___ [Required if the State mandatorily enrolls any of the children with special needs listed above] The State has required the MCOs/PHPs to provide case management services to children with special needs. Please describe *(Your description may refer to your response in Section F.II.a)*.

3.___ [Required if the State mandatorily enrolls any of the children with special needs listed above] The State has developed and

implemented a process to collaborate and coordinate with agencies and advocates which serve special needs children and their families. Please describe *(Your description may refer to your response in Sections A.I, A.III.b, C.VII.a.3, and F.I.c)*.

4.___ [Required if the State mandatorily enrolls any of the children with special needs listed above] The State has a process for coordination with other systems of care (for example, Medicare, HRSA Title V grants, Ryan White CARE Act, SAMHSA Mental Health and Substance Abuse Block Grant Funds) or State/local funding sources. Please describe *(Your description may refer to your response in Section F.I.d)*.

5.___ [Required if the State mandatorily enrolls any of the children with special needs listed above] The State requires the MCO/PHP to coordinate health care services for special needs children with: providers of mental health, substance abuse, local health department, transportation, home and community based waiver, developmental disabilities, and Title V services. Please describe *(Your description may refer to your response in Section B.V and Section B.VI)*.

h.___ Quality of Care Monitoring [Required if the State mandatorily enrolls any of the children with special needs listed above] The State performs functions in the quality of care monitoring for children with special needs, including:

1.___ [Required if the State mandatorily enrollsany of the children with special needs listed above] The State has some specific performance measures for children with special needs (for example, CAHPS for children with special needs, HEDIS measures stratified by special needs children, etc.). Please describe *(Your description may refer to your response in Section C.VII.b and Section F.I.g)*.

2.___ [Required if the State mandatorily enrolls any of the children with special needs listed above] The State has specific performance improvement projects that address issues for children with special health care needs. Please describe *(Your description may refer to your response in Section C.VII.d and Section F.I.g).*

i.___ BBA Safeguards [Required if the State mandatorily enrolls children with special needs listed above] To the extent appropriate, the State has adequately addressed Balanced Budget Act (BBA) guidance that HCFA has

issued to date. Please describe.

j.___ Payment Methodology [Required if the State mandatorily enrolls any of the children with special needs listed above] The State develops a payment methodology that accounts for special needs populations enrolled in capitated managed care. Please describe *(Your description may refer to your response in Section D.III.l)*.

k.___ Plan Monitoring [Required if the State mandatorily enrolls any of the children with special needs listed above] The State performs functions in the monitoring of plans for children with special needs, including:

1.___ [Required if the State mandatorily enrolls any of the children with special needs listed above] The State has in place a process for monitoring children with special needs enrolled in MCOs/PHPs for access to services, quality of care, coordination of care, and enrollee satisfaction. Please describe *(Your description may refer to your response in Section F.I.e)*.

2.___ [Required if the State mandatorily enrolls any of the children with special needs listed above] The State has standards or efforts in place regarding MCOs'/PHPs' compliance with ADA access requirements for enrollees with physical disabilities. Please describe *(Your description may refer to your response in Section F.I.f)*.

3.___ [Required if the State mandatorily enrolls any of the children with special needs listed above] The State defines medical necessity for MCOs/PHPs and the State monitors the MCOs/PHPs to assure that it is applied by the MCOs/PHPs in their service authorizations. Please describe *(Your description may refer to your response in Section F.II.f)*.

Section G. Complaints, Grievances, and Fair Hearings

MCOs/PHPs are required to have an internal grievance procedure approved in writing by the State agency, providing for prompt resolution of issues, and assuring participation of individuals with authority to order corrective action. The procedure allows an enrollee or a provider on behalf of an enrollee to challenge the denial of coverage of, or payment for services as required by 1932(b)(4) of the Act.

States are required to provide Medicaid enrollees with access to the State fair hearing process as required under 42 CFR 431 Subpart E, including:

- informing Medicaid enrollees about their fair hearing rights in a manner that assures notice at the time of an action,
- ensuring that enrollees may request continuation of benefits during a course of treatment during an appeal or reinstatement of services if State takes action without the advance notice and as required in accordance with State Policy consistent with fair hearings. The State must also inform enrollees of the procedures by which benefits can be continued for reinstated, and
- other requirements for fair hearings found in Subpart E.

I. Definitions:

Previous Waiver Period

a.___ During the last waiver period, complaints and grievances were defined differently than described in the waiver governing that period. The differences were:

Upcoming Waiver Period -- Please identify any responses that reflect a change in program from the previous waiver submittal(s) by placing two asterisks (i.e., "**") after your response.

a. Please provide definitions used by the State for complaint, grievance, or appeal.

b. Please describe any special processes that the State has for persons with special needs.

II. State Requirements and State Monitoring Activities:

Previous Waiver Period

a.___ During the last waiver period, the grievance standards or State monitoring were different than described in the waiver governing that period. The differences were:

b. [Required for all elements checked in the previous waiver submittal] Please provide results from the State's monitoring efforts, including a summary of any analysis and corrective action taken with respect to complaints, grievances and fair hearings for the previous waiver period [items G.II.a and G.II.b of the 1999 initial preprint; as applicable in 1995 preprint]. Also, please provide summary information on the types of complaints, grievances or fair hearings during the previous two-year period following this addendum. Please note how access and quality of care concerns were addressed in the State's Quality Improvement Strategy.

c. Please mark any of the following that apply:

1.___ A hotline was maintained which handles any type of inquiry, complaint, or problem.

2.___ Following this section is a list or chart of the number and types of complaints and/or grievances handled during the waiver period.

3.__ There is consumer involvement in the grievance process. Please describe.

Upcoming Waiver Period -- For items a. and b. of this section, please identify any responses that reflect a change in program from the previous waiver submittal(s) by placing two asterisks (i.e., "**") after your response. Please check any State requirements and State monitoring activities in effect for MCO/PHP grievance processes.

a. Required Complaints, Grievances, and Fair Hearings Elements:

1.___ The State requires MCO/PHPs to have a written internal grievance procedure, providing for prompt resolution of issues and assuring participation of individuals in authority.

2.___ The MCO/PHP grievance process is approved by the State prior to its implementation.

3.___ An MCO/PHP enrollee can request a State fair hearing under the State's Fair Hearing process. Please explain how, under what circumstances (i.e., direct access or exhaustion), and when an enrollee can access the State Fair Hearing process_____

4.___ Enrollees are informed about their fair hearing rights at the time of Medicaid eligibility determination and at the time of any action as defined in 42 C.F.R. 431 Subpart E.

5.___ The State ensures that enrollees may request continuation of benefits or reinstatement of services during a course of treatment during a fair hearing appeal. The State informs enrollees of the procedures by which benefits can be continued or reinstated.

6.___ Enrollees are informed about their complaint, grievance, and fair hearing rights at the time of MCO/PHP enrollment and/or on a periodic basis thereafter. Please specify how and through what means enrollees are informed._____

b. Optional Complaints, Grievances, and Fair Hearings Elements:

1.___ The internal grievance procedure required by the State is characterized by the following (please check any of the following optional procedures that apply to the State's required grievance procedure):

(a)__ The MCO/PHP governing body approves the grievance procedure and is responsible for the effective operation of the grievance process.

(b)__ The governing body or its delegated grievance committee reviews and resolves complaints and grievances. If the State has any committee composition requirements please list_____

(c)__ Reviews requests for reconsideration of initial decisions not to provide or pay for a service.

(d)__ Specifies a time frame from the date of action for the enrollee to request a grievance resolution or fair hearing. Specify the time frame _____

(e)__ Includes time frames for resolution of grievances for MCO/PHP grievances. Specify the time frame set by the State _____

(f)__ Establishes and maintains an expedited grievance review process for the following reasons:_____ Specify the time frame set by the State for this process____

(g)__ Permits enrollees to appear before MCO/PHP personnel responsible for resolving the grievance.

(h)__ Provides that, if the grievance decision is adverse to the enrollee, the grievance decision and any supporting documentation is forwarded to the State within a time frame specified by the State. Specify the time frame____.

(i)__ The MCO/PHP acknowledges receipt of each complaint and grievance when received and explains to the enrollee the process to be followed in resolving his or her issue. If the State has a time frame for MCOs/PHPs to acknowledge complaints and grievances, please specify:

(j)__ Gives enrollees assistance completing forms or other assistance necessary in filing complaints or grievances (or as complaints and grievances are being resolved).

(k)__ Conducts grievance resolution/hearings using impartial individuals not involved in previous levels of decision making.

(l)__ If the focus of the grievance is a denial based on lack of medical necessity, one of the reviewers is a physician with appropriate expertise in the field of medicine that encompasses the enrollee's condition or disease.

(m)__ Bases the MCO/PHP's decision on the record of the case.

(n)__ Notifies the enrollee in writing of the grievance decision and further opportunities for appeal, as well as the procedures available to challenge or appeal the decision.

(o)__ Upon request, provides enrollees and potential

enrollees with aggregate information regarding the nature of enrollee complaints and grievances and their resolution.

(p)__ Sets time frames for the MCO/PHP to authorize or provide a service if decision is overturned or reversed through the grievance or fair hearing process. Specify the time frame____

(q)__ Informs the enrollee of any applicable mechanism for resolving the issue external to the MCOs/PHPs own processes.

(r)__ Determines whether the issue is to be resolved through the grievance process, the process for making initial determinations on coverage and payment, or the process for resolution of disputed initial determinations.

(s)__ Other (please explain):

2.___ MCOs/PHPs maintain a log of all complaints and grievances and their resolution.

3.___ MCOs/PHPs send the State a summary of complaints and grievances on at least an annual basis.

4.___ The State requires MCOs/PHPs to maintain, aggregate, and analyze information on the nature of issues raised by enrollees and on their resolution.

5.___ The State requires MCOs/PHPs to conduct in-depth reviews of providers or services identified through summary reports as having undesirable trends in complaints and grievances.

6.___ The State and/or MCO/PHP have ombudprograms to assist enrollees in the complaint, grievance, and fair hearing process.

7.___ Other (please specify):

Section H. Enrollee Information and Rights

This section describes the process for informing enrollees and potential enrollees receive about the waiver program, and protecting their rights once enrolled. The information in this section (e.g., enrollee handbooks, enrollment information, PCP choice materials) is considered to be marketing material because it is sent directly to enrollees. However, the traditional marketing materials (e.g., billboards, direct mail, television and radio advertising) are addressed above in Section A (see A.III.a).

I. Enrollee Information - Understandable to Enrollees:

Previous Waiver Period

a.___ During the last waiver period, the requirements for understandable enrollee information operated differently than described in the waiver governing that period. The differences were:

b. [Required] Please provide copies of the brochure and informational materials explaining the program and how to enroll.

Upcoming Waiver Period -- This section describes how the State ensures information about the waiver program is understandable to enrollees and potential enrollees. Please check all the items which apply to the State or MCO/PHP. For all items in this section, please identify any responses that reflect a change in program from the previous waiver submittal(s) by placing two asterisks (i.e., "**") after your response. Items which are required have "[Required]" in front of them. Checking a required item affirms the State's intent to comply. If the State does not check a required item, please explain why.

a.___ [Required] The State will ensure that enrollee materials provided to enrollees by the State, the enrollment broker, and the MCO/PHP are clear and easily understandable.

b.__ Enrollee materials will be translated into the languages listed below (If the State does not translate enrollee materials, please explain):

The State has chosen these languages because (check any that apply):

1.__ The languages comprise all prevalent languages in the MCO/PHP service area.

2.__ The languages comprise all languages in the MCO/PHP

service area spoken by approximately ___ percent or more of the population.

3.__ Other (please explain):

c.___ Program information is available and understandable to non-English speaking enrollees whose language needs are not met through the provision of translated material described above. Please describe.

d.___ [Required] Translation services are available to all enrollees, regardless of languages.

e.__ Every new enrollee will have access to a toll-free number to call for questions. Please note if the State requires TTY/TDD for those with hearing/speech impairments:

f.___ The State requires MCO/PHP enrollee information materials to be translated into alternative formats for those with visual impairments.

II. Enrollee Information - Content:

Previous Waiver Period

a.___ During the last waiver period, the enrollee information requirements operated differently than described in the waiver governing that period. The differences were:

Upcoming Waiver Period -- This section describes the types of information given to enrollees and potential enrollees. Please check all that apply. For all items in this section, please identify any responses that reflect a change in program from the previous waiver submittal(s) by placing two asterisks (i.e., "**") after your response. Items which are required have "[Required]" in front of them. Checking a required item affirms the State's intent to comply. If a required item is not check, please explain why.

a. Information provided by the State and/or its Enrollment Broker. The State and/or its enrollment broker provides the following information to enrollees and potential enrollees.

1.___ Every new enrollee will be given a brief in-person presentation describing how to appropriately access services under the managed care system and advising them of enrollees' rights and responsibilities

2.___ An initial notification letter

3.___ Informational materials describing how to appropriately access services under the managed care system and advising them of enrollees' rights and responsibilities.

4.___ A form for enrollment in the waiver program and selection of a plan

5.___ A list of plans serving the enrollee's geographical area

6.___ Comparative information about plans

7.___ Information on how to obtain counseling on choice of MCOs/PHPs

8.___ Detailed provider network listings

9.___ A new Medicaid card which includes the plan's name and telephone number or a sticker noting the plan and/or PCP's name and telephone number to be attached to the original Medicaid card (please specify which method);

10.__ A health risk assessment form to identify conditions requiring immediate attention.

11.__ Information concerning the availability of special services, expertise, and experience offered by MCO/PHPs and providers

12.__ [Required] Information explaining the grievance procedures and how to exercise due process rights and their fair hearing rights.

13.__ [Required for MCOs with lock-in periods] Information about their right to disenroll without cause the first 90 days of each enrollment period. (See A.III.b.5)

14.__ [Required for MCOs] Information on how to obtain services not covered by the MCO/PHP but covered under the State plan.

15.__ [Required for MCOs] For enrollees in lock-in period, notification 60 days prior to end of enrollment period of right to change MCOs/PHPs (See A.III.b.5)

16.__ Other items (please explain):

b. Information provided by the MCO/PHP The State requires the MCO/PHP to provide, written information on the following items to enrollees and potential enrolles. Unless otherwise noted, required items must be provided upon actual enrollment into the MCO/PHP (the BBA requires some information be provided only upon request). Please check all that apply.

1.___ [MCOs required to provide upon request] Enrollee rights.

2.___ [MCOs required to provide upon request] Enrollee responsibilities.

3.___ [MCOs required to provide upon request] Names, locations, qualifications and availability of network providers, including information about which providers are accepting new Medicaid enrollees and any restrictions on enrollees' ability to select from among network providers.

4.___ [MCOs required to provide upon request] Amount, duration and scope of all benefits (included and excluded).

5.___ [MCOs required to provide upon request] Physician incentive program, including (1) if the MCO has a PIP that covers referral services; (2) the type of incentive arrangement; (3) whether stop-loss protection is provided; and (4) a summary of survey results, if a survey is required.

6.___ [Required for MCOs] The MCO enrollee materials (either through the enrollee handbook, semi-annual or annual open enrollment materials, or by some other means) annually disclose to enrollees their right to adequate and timely information related to physician incentives.

7.___ [MCOs and PHPs required to provide upon request *and* upon enrollment] Information explaining the complaints and grievance procedures for resolving enrollee issues, including issues relating to authorization of, coverage of, or payment for services.

8.___ [Required for MCOs] Procedures for obtaining services,

including authorization requirements.

9.___ [Required for MCOs] After-hours and emergency coverage. The State ensures enrollee access to emergency services by requiring the MCO to provide the following information to all enrollees [note: these items are required of MCOs only; however, please fill in if applicable for PHPs]:

i.___ the right to use participating and non-participating providers

ii.___ definition of emergency services

iii.__ the prudent layperson definition of emergency medical condition

iv.__ the prohibition on retrospective denials for services that meet the prudent layperson definitions (e.g., to treat what appeared to the enrollee to be an emergency medical condition at the time the enrollee presents at an emergency room)

v.__ the right to access emergency services without prior authorization

10.__ [Required for MCOs] Procedures for obtaining non-covered or out-of-area services.

11.__ [Required for MCOs] Any special conditions or charges that may apply to obtaining services.

12.__ [Required for MCOs and PHPs] The right to obtain family planning services from any Medicaid-participating provider

13.__ [Required for MCOs] Policies on referrals for specialty care and other services not furnished by the enrollee's primary care provider.

14.__ [Required for MCOs] Charges to enrollees, if applicable.

15.__ [Required for MCOs] Procedures for changing primary care providers.

16.__ Procedures for obtaining mental health, substance abuse, and developmental disability services.

17.__ Procedures for recommending changes in policies or services.

18.__ The covered service area.

19.__ Notification of termination or changes in benefits, services, service sites, or affiliated providers (if the enrollee is affected). Notices are provided in a timely manner.

20.__ A description of new technology or new technology acceptance policies which are included as covered benefits.

21.__ Enrollees' right to obtain information about the MCO/PHP, including information standards, utilization control procedures and the financial condition of the organization.

22.__ Other (please describe):

III. Enrollee Rights:

Previous Waiver Period

a.___ During the last waiver period, the requirements for enrollee rights operated differently than described in the waiver governing that period. The differences were:

Upcoming Waiver Period -- For items a. through n. of this section, please identify any responses that reflect a change in program from the previous waiver submittal(s) by placing two asterisks (i.e., "**") after your response. Please check any of the processes and procedures in the following list the State requires to ensure that contracting MCOs/PHPs protect enrollee rights. The State requires MCOs/PHPs to:

a.___ Have written policies with respect to enrollee rights.

b.___ Communicate policies to enrollees, staff and providers.

c.___ Monitor and promote compliance with their policies by staff and providers.

d.___ Ensure compliance with Federal and State laws affecting the rights of

enrollees such as all Civil rights and anti-discrimination laws.

e.___ Implement procedures to ensure the confidentiality of health and medical records and of other information about enrollees.

f.___ Implement procedures to ensure that enrollees are not discriminated against in the delivery of medically necessary services.

g.___ Ensure that all services, both clinical and non-clinical, are accessible to all enrollees, including special populations.

h.___ Ensure that each enrollee may select his or her primary care provider from among those accepting new Medicaid enrollees.

i.___ Ensure that each enrollee has the right to refuse care from specific providers.

j.___ Have specific written policies and procedures that allow enrollees to have access to his or her medical records in accordance with applicable Federal and State laws.

k.___ Comply with requirements of Federal and State law with respect to advance directives.

l.___ Have specific written policies that allow enrollees to receive information on available treatment options or alternative courses of care, regardless of whether or not they are a covered benefit.

m.__ Allow direct access to specialists for beneficiaries with long-term or chronic care needs (e.g., severely and persistently mentally ill adults or severely emotionally disturbed children)

n.__ Other (please describe):

IV. Monitoring Compliance with Enrollee Information and Enrollee Rights

Previous Waiver Period

a.___ During the last waiver period, the State monitored compliance with enrollee information and rights differently than described in the waiver governing that period. The differences were:

b. [Required for all elements checked in the previous waiver submittal]

Please include the results from monitoring MCO/PHP enrollee information and rights in the previous two year period, including a summary of any analysis and corrective action taken [items H.IV.a-d of 1999 initial preprint; item A.22 of 1995 preprint].

Upcoming Waiver Period -- For items a. through d. of this section, please identify any responses that reflect a change in program from the previous waiver submittal(s) by placing two asterisks (i.e., "**") after your response. Please check any of the processes and procedures the State uses to monitor compliance with its requirements for enrollee information and rights.

a.___ The State tracks disenrollments and reasons for disenrollments or requires MCOs/PHPs to track disenrollments and reasons for disenrollments and to submit a summary to the State on at least an annual basis.

b.___ The State will approve enrollee information prior to its release by the MCO/PHP.

c.___ The State will monitor MCO/PHP enrollee materials for compliance in the following manner (please describe):

d.__ The State will monitor the MCO/PHPs compliance with the enrollee rights provisions in the following manner (please describe):

Section I. Resource Guide

Below are references which provide information related to Medicaid managed care quality assessment and improvement efforts, and rate setting and risk adjustment methodologies:

Actuarial Research Corporation, Report prepared for the Department of Health and Human Services (DHHS)/the Health Care Financing Administration (HCFA), Capitation Rate Setting in Areas with Eroded Fee-For-Service Base Final Report, 1992.

Actuarial Research Corporation, Setting an Upper Payment Limit Where the Fee for Services Base is Inadequate: Final Report, 1992.

Alpha Center, Report produced for the Robert Wood Johnson Foundation, Risk Adjustment: A Special Report, 1997.

Ann Arbor Actuaries, Inc., Report prepared for DHSS/HCFA, A Review of Rate Setting Methods of Selected State Medicaid Agencies for Prepaid Health Plans, 1991.

Ann Arbor Actuaries, Inc., Report prepared for DHSS/HCFA, Actuarially Sound Rate Setting Methodologies, 1991.

Conference Report 105-217 to accompany H.R. 2015, the Balanced Budget Act of 1997, (Section 4705 and the regulations being developed to implement these requirements).

Foundation for Accountability (FACCT), Foundation for Accountability (FACCT) Guidebook for Performance Measurement Prototype Summary, 1995.

Independent Assessment Guide Document, Health Care Financing Administration, December, 1998.

Joint Commission for Accreditation of Healthcare Organizations, National Library of Health Care Indicators, 1997.

Massachusetts Medical Society, Quality of Care: Selections from The New England Journal of Medicine, 1997.

Mathematica Policy Research, Inc, The Quality Assurance Reform Initiative (QARI) Demonstration For Medicaid Managed Care: Final Evaluation Report, 1996.

MEDSTAT Group, Report prepared for U.S. DHHS/HCFA, A Guide for States: Collecting and Analyzing Medicaid Managed Care Data, 1997.

MEDSTAT Group, Report prepared for U.S. DHHS/HCFA, Survey of Key Performance Indicators, 1997.

Medicaid Management Institute of the American Public Welfare Associations, report prepared for DHHS/HCFA, Medicaid Primary Care Case Management Programs: Guide for Implementation and Quality Improvement, 1993.

Merlis, Mark for National Governor's Association (NGA), Medicaid Contracts with HMOs and Pre Paid Health Plans: A Handbook for State Managers, 1987. (**Rate Setting Description still applicable)

National Academy for State Health Policy, Quality Improvement Primer For Medicaid Managed Care, 1995.

National Academy for State Health Policy, Quality Improvement Standards and Processes Used by Select Public and Private Entities to Monitor Performance of Managed Care: A Summary, 1995.

National Academy for State Health Policy, Report prepared for HCFA, Quality Improvement System for Managed Care, 1997.

National Committee for Quality Assurance (NCQA), Health Plan Employer Data and Information Set (HEDIS © Current Version).

President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry, Final report to the President of the United States, Quality First: Better Health Care for All Americans, 1998.

U.S. DHHS/HCFA, A Health Care Quality Improvement System for Medicaid Managed Care: A Guide for States, 1993.

U.S. DHHS/PHS/AHCPR, Conquest 1.1: A Computerized Needs-Oriented Quality Measurement Evaluation System, 1996.

U.S. DHHS/PHS/AHCPR, Consumer Assessment of Health Plans (CAHPS) Satisfaction Survey, 1997.

U.S. DHHS/PHS/AHCPR, Putting Research to Work in Quality Improvement and Quality Assurance: Summary Report, 1993, Publication No. 93-0034.

U.S. DHHS/PHS/AHCPR Research Activities Newsletter, Monthly publication.

U.S. DHHS/HCFA and National Committee on Quality Assurance (NCQA), Health Care Quality Improvement Studies in Managed Care Settings: Design and Assessment: A Guide for State Medicaid Agencies, 1994, Purchase Order #HCFA-92-1279.

U.S. DHHS/HCFA/American Public Welfare Association (APWA), Monitoring Risk-Based Managed Care Plans: A Guide for State Medicaid Agencies.

U.S. DHHS/PHS/SAMHSA, Managed Care Initiative Quality Improvement Publications: "Managing Managed Care: Quality Improvement in Behavioral Health."*

U.S. DHHS/PHS/SAMHSA, Managed Care Initiative Technical Assistance Publications: Volume One, "An Evaluation of Contracts Between Managed Care Organizations and Community Mental Health and Substance Abuse Treatment and Prevention Agencies."*

U.S. DHHS/PHS/SAMHSA, Managed Care Initiative Technical Assistance Publications: Volume Two, "An Evaluation of Contracts Between State Medicaid Agencies and Managed Care Organizations for the Prevention and Treatment of Mental Illness and Substance Abuse Disorders."*

U.S. DHHS/PHS/SAMHSA, Managed Care Initiative Technical Assistance Publications: Volume Seven, "Technical Assistance Publication Series (TAP) 22: Contracting for Managed Substance Abuse and Mental Health Services: A Guide for Public Purchasers."*

Websites: www.hcfa.gov, www.ahcpr.gov or outside organizations such as www.ncqa.org, www.nashp.org, www.samhsa.gov, www.apwa.org.

*document can be ordered through the National Clearinghouse on Alcohol and Drug Information (NCADI) 800/729-6686 or found on the SAMHSA Web Site at www.samhsa.gov/mc/TAS.htm.